



Tuesday, September 20, 2016

DeVos Place, Grand Rapids

General Information

Going Green

No paper packets, handouts or flash drives will be provided at the conference today. All materials can be downloaded at http://www.michigan.gov/lara/0,4601,7-154-35299_63294-290587--,00.html.

Continuing Education Credits

If you will be requesting Continuing Education Credits (RN, LPN, NHA, or SW), you must print and sign your name on your Professional Discipline Sheet at your profession's CE table in the Lansing Center Lobby by 9:15 am on Tuesday, September 20, 2016.

Evaluations will be online and must be completed by Friday, October 14, 2016.

Internet Access

Username: jpst2016

Password: devosplace

Parking

The Bureau of Community and Health Systems will validate participants parking who park at **The DeVos Place Ramp or Government Center Ramp**. The green validation slip will only work for these parking ramps. When Parking in the DeVos Parking Ramp, Sections A,B and Care closest to the ballrooms. The validation slips will not work for The Amway Grand Plaza Hotel Ramp.

You can pick up your green validation slip when you register.

As participants exit the parking structures, you must present both your validation slip and your parking ticket to the attendant to receive the validated parking. Attendants are not permitted to validate your parking if you do not have the green validation slip.

If there is not an attendant when you exit, you will complete the same process with the Pay In Lane Machine. You will input your parking ticket and when it asks for payment, you will input the green validation slip.

Directions to vending machine

From Ballrooms: go north out of the Secchia Lobby and take a right into the Grand Gallery Lobby. The vending machine is on the right hand side in front of the Box Office. There is also an ATM machine there.

Joint Provider Dates

Tuesday, March 28, 2017-DeVos Place, Grand Rapids, MI

Wednesday, September 27, 2017- Lansing, Center, Lansing, MI

Tuesday, April 10, 2018- Lansing Center, Lansing, MI

Presenter Biographies

Heather Alexander, MSPM

Client Service Manager

Prometric

Heather.alexander@prometric.com

Ms. Alexander brings to her position 18 years of testing experience with certification programs. In her prior positions, she oversaw aide program transitions, managed contractual and operational elements, drove operational efficiency, and conducted audits to assess client satisfaction. Ms. Alexander has also held a variety of program management positions where she was responsible for managing client operations, implementing new programs, monitoring operational functions, conducting test center and program-specific training, developing and conducting customer presentations, preparing budgets, overseeing contractual reporting, and leading contract negotiations.

Ms. Alexander has a master's degree with a concentration in project management.

Jerry A. Barkoff

State Administrative Manager

State of Michigan, BCHS Federal Survey and Certification Division, LARA

barkoffj@michigan.gov

Jerry has been employed with the State of Michigan since 1993. He was a surveyor for 22 years and is now a Manager with the Federal Survey and Certification Division in Detroit. He has dual Master Degrees in both Social Work and Counseling and is a Licensed Master Social Worker in Michigan. He has been credentialed with the distinction of ACSW (Academy of Certified Social Workers) since 1995.

Vickie Burlew RN, ADNS

Health Care Consultant

Lebenbom & Rotham, PC

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Vickie Burlew is a registered nurse and licensed nursing home administrator. She has been actively involved in the culture change movement as a Certified Eden Associate, Education/Mentor and Guide. She is currently employed as a Health Care Consultant with a law firm specializing in long term care.

Vickie's focus is facilitating long term care homes to be successful in regulatory matters in times of crisis and in their efforts toward person-directed care. She has been developing Directed Plans of Correction since 2002.

Rebecca Ferrini, MD, MPH, CMD**Medical Director****San Diego County Edgemoor Facility****rferrini@san.rr.com**

Rebecca Ferrini, MD, MPH, CMD, is currently the Medical Director for the County of San Diego's Edgemoor DP-SNF Facility. She obtained her MD at the University of California, San Diego School of Medicine and has specialties in General Preventive Medicine, Hospice and Palliative Medicine and is an AMDA Certified Medical Director. She was honored in 2009 as the AMDA Medical Director of the Year for her work in improving her facility to a five star nationally recognized center. Dr. Ferrini has also published many works in the long-term care field giving special attention to the younger adult population living in these settings. She is the chief developer of the AMDA Younger Adult in the Long-Term Care Setting toolkit and will be conducting trainings throughout several states to help caregivers provide a higher quality of care to these younger adult residents.

Jessica Harback, RN, BSN**Manager*****State of Michigan, BCHS*****harbackj@michigan.gov**

Jessica Harback is the section manager for the CLIA program and the Dialysis Ambulatory Surgery Center, and Hospital (DASH) section. Jessica has been with the Department of Licensing and Regulatory Affairs for four years as a healthcare surveyor, stepping into the role of manager in January. Her nursing background is in Emergency Room nursing.

Kimberly Harrell, BS, LNHA, SWT**Administrator*****Olympia Group (Father Murray Nursing & Rehabilitation Center)*****kharrell@olympiagroupllc.com**

Kimberly has 16 years of experience as a licensed Nursing Home Administrator with a 24-year Social Work background in long term care.

Karen Hinkle, NHA, BBSW**Administrator*****Countryside Care Center, Inc.*****khinkle@qantons.com**

Karen's experience in the long term care industry started as a CNA part time while in college. She really enjoyed working with seniors and so became a social worker in the skilled nursing arena. Karen has seen many changes in the industry since her early days. Her experience as a CNA has helped her to relate with the CNA's and understand what a hard job they really have. She has worked at Countryside since 1997 – first as a social worker and in 2010 became the administrator. Karen has been part of the MI-POST initiative since the mid 1980's and worked with several groups in the Jackson area with a focus on long term care. She is an advocate for person centered care.

Amy Holden, RN**Health Care Surveyor*****State of Michigan, BCHS*****holdena@michigan.gov**

Ms. Holden graduated from Kellogg Community College in 1992. She has spent 20 years as a long term care provider prior to becoming a surveyor in 2010.

Dakima Jackson

Long Term Care Ombudsman

The Senior Alliance

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Dakima Jackson is a Certified Local Long Term Care Ombudsman for Western Wayne County at the Senior Alliance Area Agency on Aging 1-C. She has been involved in the advocacy network for 15 years. Ms. Jackson began her career working with developmentally disabled adults in adult foster care homes, elders in nursing homes, and in assisted living facilities. Ms. Jackson holds a Masters of Health Services Administration degree from the University of Detroit Mercy.

She is involved in many advocacy groups such as the Wayne County Best Practice Committee, the National Consumer Voice for Long Term Quality Care, the Coordinated Community Response Coalition, and facilitated the Western Wayne County Regional Family Council. Her passion in resolving elder abuse issues granted her the opportunity to speak on elder abuse topics to the health care community and the community at large.

Stacey Lawson, BA

Team Lead

Prometric

StacyLawson@prometric.com

Stacy Lawson, an Executive at Prometric since 2004, is a team leader in Prometric's healthcare portfolio with primary responsibilities for Prometric's 11 Nurse Aide testing and certification programs as well as several other healthcare licensure/certification programs. She focuses her attention on healthcare and state-based clients in the United States and is responsible for developing and maintaining relationships with both new and existing clients.

Ms. Lawson has more than 28 years of comprehensive management, sales and Account experience. She has been a participant in Prometric's recent Nurse Aide National Examination Council meetings and a key member of new client program implementation teams for Internet-based testing certification examination programs for Nurse aides in Hawaii and home care aides in Washington. Previously, she was Director of Marketing and Sales for a technology company providing products and services to government agencies.

Ms. Lawson has Bachelor's degrees in Biomedical Engineering and Electrical Engineering from Duke University.

Susan M. Levy, MD, CMD

Independent Consultant

Self-employed

susan@susanlevymd.com

Dr. Susan M. Levy has been a medical director for over twenty-five years. She is currently the President of AMDA, The Society for Post-Acute and Long Term Care Medicine.

Dr. Levy earned her medical degree from the University of Maryland and completed an Internal Medicine residency at the Medical University of South Carolina. She also completed a geriatric fellowship at the Mount Sinai Medical Center in New York. She returned to Baltimore as Section Chief of Geriatric Medicine for a community hospital in Baltimore. She later became the Vice President of Medical Affairs for Levindale Hebrew Geriatric Center and Hospital. She currently resides in Delaware where she is medical director of two nursing homes and does additional consulting work related to geriatric medicine including PA/LTC.

Dr. Levy is board certified in Internal Medicine, Geriatric Medicine, and Hospice and Palliative Medicine. Dr. Levy has been a Certified Medical Director since 1996 and has served as the President of the Maryland Medical Directors Association from 2004 to 2008.

Jodi L. Menzies, RN, RAC-CT

MDS Coordinator; Clinical Reimbursement Specialist in Jackson

Pines Rehabilitation and Health Care Center; will be transferring to Jackson County Medical Care Facility in September

pyxiejo@gmail.com

Ms. Menzies received her nursing degree in 2008 and passed the RN NCLEX in February of 2009. She started as a floor nurse at the Pines the following week. In 2010, when MDS changed from 2.0 to 3.0, all of the MDS nurses chose to move on and she began MDS in early October of 2010, and has been practicing as the MDS Coordinator. In June of 2011, Jodi attended a workshop presented by the American Association of Nurse Assessment Coordinators, and achieved her Resident Assessment Coordinator certification, which has been maintained.

Haiden Najafi, RN, BSN, MSED, EDS

RAI/MDS & OASIS Educational Coordinator, Nurse Consultant

State of Michigan, BCHS

najafih@michigan.gov

Haideh Najafi holds Bachelor degrees in Nursing and Physical Education, Master degrees in Physical and Special Education, and an Educational Specialist degree (Ed.S) in Special Education all from Michigan State University.

Haideh worked as a Science teacher, a Special Education teacher, and an RN in the Cardiac unit. She also worked as home health, hospice, and nursing home surveyor, complaint investigator and trainer for the State of Michigan for 21 years. She has worked as an OASIS Educational Coordinator since 2004, and as an RAI/MDS coordinator since 2010. She has been married for 42 years and has two sons, and three grandsons.

Tom Novak

Enforcement & Compliance Section Manager

State of Michigan, BCHS

NovakT1@Michigan.gov

Tom began working for the State of Michigan in 1989. Before joining the Bureau of Community and Health Systems in 2014, he had previously worked for the Unemployment Insurance Agency, Child Protective Services, and the Department of Mental Health.

John Rojeski

State Administrative Manager

State of Michigan, BCHS

RojeskiJ@michigan.gov

John has been with the Long Term Care Division/Federal Survey & Certification Division for the past eight years as manager of the Complaint Investigation Unit and Licensing Officer.

John has prior experience with the Michigan State Police as an IT Project Manager and Manager of the Law Enforcement Information Network. He retired as a Detective Lieutenant from a local law enforcement agency with 27 years of experience as a police officer; worked primarily upper-level narcotics trafficking and organized crime for majority of his career.

James D. Scott, PE**Manager, Health Facilities Evaluation Section*****State of Michigan, BCHS*****ScottJ6@michigan.gov**

James D. Scott, P.E., manages the Health Facilities Evaluation Section (HFES), a position he also held from 2000 to 2010. In this position, he oversees the approval of construction of Long-term care facilities under the Public Health Code. He also supervises the staff who conduct Life Safety Code surveys of long term care facilities. He was Director of the Division of Health Facilities & Services in the Bureau of Health Systems from 2010 to 2013.

Jim has been with the HFES staff since 1984. He represented HFES on the committee which developed the Minimum Design Standards for Health Care Facilities in Michigan. He chairs the Health Facilities Planning Seminar committee and represents the State of Michigan on the Health Guidelines Revision Committee.

Sarah Slocum, MA**State Long Term Care Ombudsman*****State of Michigan*****slocums@michigan.gov**

Sarah Slocum is Michigan's State Long Term Care Ombudsman. She has served in this capacity at the Michigan Office of Services to the Aging since December 1, 2003. Prior to this appointment, Ms. Slocum served as long term care policy staff for AARP Michigan from 2001 to 2003. Her service at AARP followed seven and one half years as director of the statewide Medicare Medicaid Assistance program. Ms. Slocum served as an Assistant State LTC Ombudsman at Citizens for Better Care from 1984 to 1994, and prior to that spent one year as a VISTA volunteer working for the Area Agencies on Aging Association of Michigan. Ms. Slocum relies on her 30-plus years of experience in service to Michigan seniors and people with disabilities as she works toward better care and quality of life for Michigan's long term care consumers.

Hollis Turnham, J.D., BA**Michigan Manager*****PHI – Quality Care through Quality Jobs*****hturnham@PHInational.org**

Turnham is the Michigan Manager for PHI. PHI works to improve the quality of eldercare and disability services by improving the jobs of direct-care workers. Hollis has over 30 years' experience in poverty and aging issues, first as a legal services attorney in Adrian, Michigan and, then as Michigan's State Long Term Care Ombudsman for almost 16 years. Prior to joining PHI, Hollis was the 1999-2000 John Heinz Senate Fellow in Aging working on aging and long-term care issues for Chairman James Jeffords (R-VT) of the U.S. Senate Committee on Health Education, Labor, and Pensions. With her experience, Hollis plays a key role in PHI's policy work in other states including Indiana, Iowa, Vermont, Maine, and North Carolina. She has served on a number of national panels, most recently the CMS Technical Expert Panel for the implementation of QAPI.

Pain Management and Compliance with Regulations: A Medical Directors Perspective

JOINT PROVIDER AND SURVEYOR TRAINING MEETING

SEPTEMBER 20, 2016 GRAND RAPIDS MICHIGAN

SUSAN M. LEVY, MD, CMD, AGSF

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Susan M. Levy, MD, CMD, AGSF: Disclosures

CMS consultant

Medical Director

President AMDA

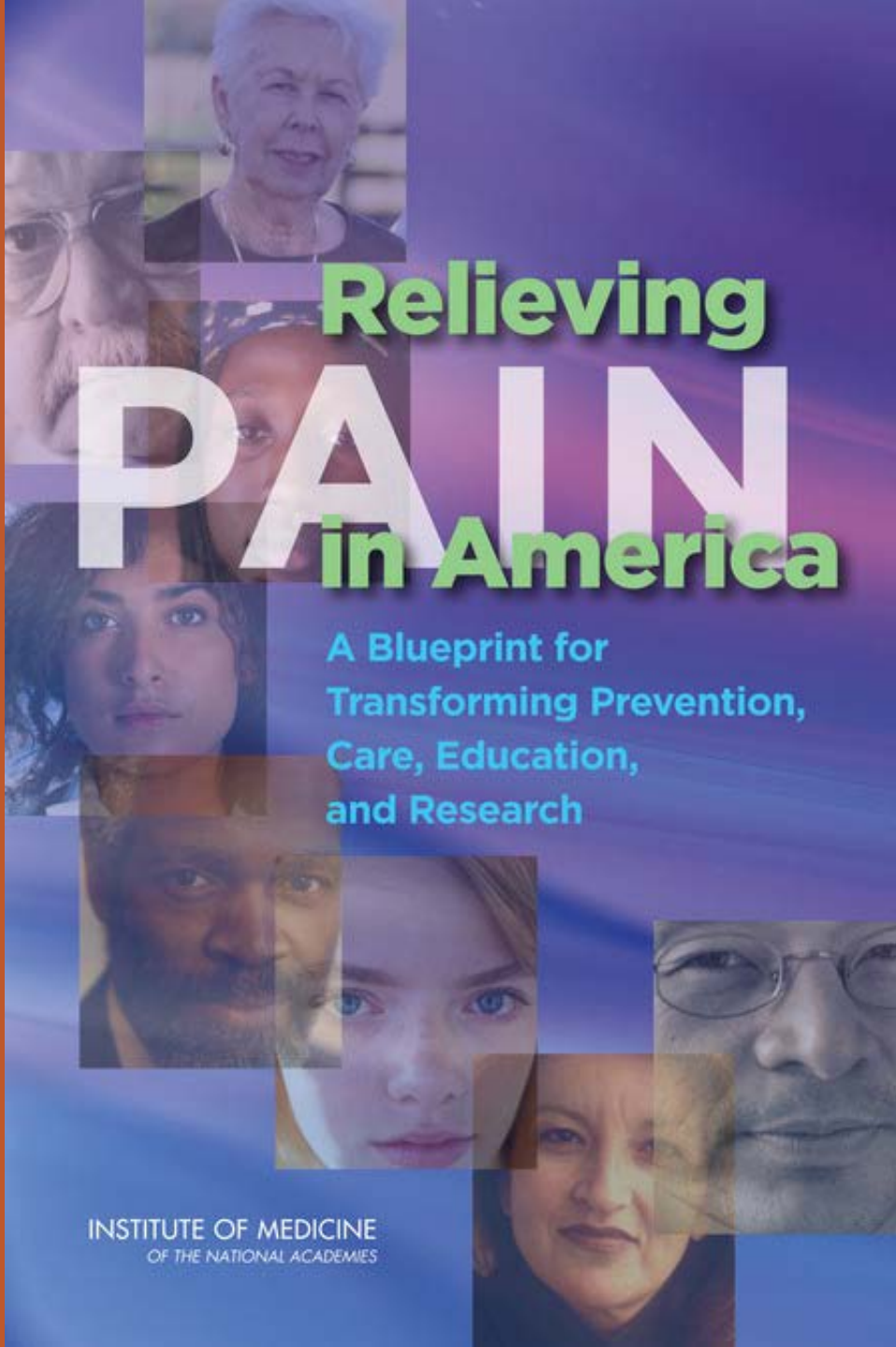
Legal case reviews

No DME/Pharmacy affiliations

Institute of Medicine Report

June, 2011

100 million American adults
635 billion dollars/year in
management and lost productivity
Cultural transformation to prevent,
assess, treat and understand pain
of all types



Pain Management in the Long Term Care Setting

CLINICAL PRACTICE GUIDELINE

Definition of Pain

Unpleasant sensory and emotional experience that can be acute, recurrent, or persistent

- Acute pain
- Chronic pain

Not part of normal aging

Resident/patient report of pain is the best indicator of pain

- Recognize many residents/patients do not or cannot report pain

Prevalence of Pain in SNF/LTC settings

49-83% - self-reporting and chart reviews (Fox, et al, CMAJ, 1999;160(3):329)

39.5-49.5% - MDS data (Teno, et al, JAMA, 2001;285(16):2081)

Conditions That Cause Chronic Pain

80% of residents have some condition that can be associated with pain

Common causes/underlying diseases

- Musculoskeletal
- Neurologic conditions
- Medications
- Diabetes

Nursing Home Quality Measures for Pain

Short stay

- Percent of Residents who Self-Report Moderate to Severe Pain

Long stay

- Percent of Residents who Self-Report Moderate to Severe Pain

Adverse effects of Pain

Depression/Anxiety

Decreased mobility/functional impairment

Agitation/Aggression

Sleep disturbance

Weight loss

Adverse Effects of Unrelieved Pain

Functional decline

Immobility

- Contractures
- Skin breakdown
- Incontinence
- Deconditioning

Quality of Life

- Depression/anxiety/sleep disturbance
- Lack of activity
- Behavior problems

Pain Management: Barriers in the Nursing Home

Poor history taking and standardized assessment

Staff turnover/lack of consistent assignment

Lack of knowledge/education

Cultural bias/ageism/health care beliefs

Access to medications



Pain Management: Barriers in the Nursing Home

Inability to communicate and/or confusion

Fear about addiction and dependence

Limited practitioner involvement and poor prescribing

Lack of family involvement

Pain Management: What Families Should Ask

(Adapted from Advancing Excellence FAST FACTS: Pain Management in Nursing Homes)

How do you measure pain and how often?

How do you document information about pain?

How do you include residents and families in care planning?

How are you treating pain? How do you know it is working?

What do you do if pain treatment is not working?

When do you notify the practitioner?

How do you monitor and manage side effects from pain drugs?

Obstacles to Good Pain Management: Lack of Comprehensive Pain Assessment Protocols

Is pain assessed and reassessed frequently or only with MDS

- Fifth vital sign
- Can't evaluate and treat if you don't ask because you won't know

Do we really have good tools/process for cognitively impaired?

Limited use of non-pharmacologic interventions

Poor prescribing (wrong drugs, dose, interval, etc.)

- Chronic pain management is multi-modal
- Opioids are not the answer to all pain

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-09-22

DATE: **January 23, 2009**

TO: State Survey Agency Directors

FROM: Director
 Survey and Certification Group

SUBJECT: **Nursing Homes** - Issuance of Revised Quality of Care Guidance at F309, including
Pain Management as Part of Appendix PP, State Operations Manual, Additional
Minor Changes Made to Appendices P and PP as Described Below

F-Tag 309 Quality of Care: Key Components of Pain Management (CARE PROCESS)

Assessment/Recognition

Management of Pain

- Non-pharmacologic interventions
- Pharmacologic Interventions

Monitoring, Reassessment, and Care Plan Revision

F-309 and Pain Management: Facility Responsibilities

Assess for the potential for pain

Recognize pain when it is present

Assess pain when identified

Observe for the impact of care, activities, and treatment on pain

Monitor regularly for the presence of pain

- Change of condition
- New pain
- Exacerbation of pain

Pain Management: Recognition

When should pain be assessed

- ◆ Upon a patient's admission to a LTC facility and at each quarterly and annual review;
- ◆ Whenever a patient has an acute illness or injury or experiences a decline in function or a change in mood or cognition;
- ◆ Whenever a patient exhibits unexpected social withdrawal or signs of depression;
- ◆ Whenever vital signs are obtained (i.e., as the "fifth vital sign");
- ◆ At least daily, for patients with a known painful condition; and
- ◆ Before and after administration of as-needed (PRN) analgesic medication.

Pain Assessment MDS 3.0: Section J

Uses standard questions for residents who can communicate

- Numeric rating
- Verbal descriptor

Has staff assessment for residents who can not communicate

- Non-verbal indicators

Pain Assessment Interview

J0300. Pain Presence

Enter Code

☐

Ask resident: "***Have you had pain or hurting at any time in the last 5 days?***"

- 0. **No** → Skip to J1100, Shortness of Breath
- 1. **Yes** → Continue to J0400, Pain Frequency
- 9. **Unable to answer** → Skip to J0800, Indicators of Pain or Possible Pain

J0400. Pain Frequency

Enter Code

☐

Ask resident: "***How much of the time have you experienced pain or hurting over the last 5 days?***"

- 1. **Almost constantly**
- 2. **Frequently**
- 3. **Occasionally**
- 4. **Rarely**
- 9. **Unable to answer**

J0500. Pain Effect on Function

Enter Code

☐

A. Ask resident: "***Over the past 5 days, has pain made it hard for you to sleep at night?***"

- 0. **No**
- 1. **Yes**
- 9. **Unable to answer**

Enter Code

☐

B. Ask resident: "***Over the past 5 days, have you limited your day-to-day activities because of pain?***"

- 0. **No**
- 1. **Yes**
- 9. **Unable to answer**

J0600. Pain Intensity - Administer **ONLY ONE** of the following pain intensity questions (A or B)

Enter Rating

A. Numeric Rating Scale (00-10)

Ask resident: "***Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine.***" (Show resident 00-10 pain scale)

Enter two-digit response. Enter 99 if unable to answer.

Enter Code

☐

B. Verbal Descriptor Scale

Ask resident: "***Please rate the intensity of your worst pain over the last 5 days.***" (Show resident verbal scale)

- 1. **Mild**
- 2. **Moderate**
- 3. **Severe**
- 4. **Very severe, horrible**
- 9. **Unable to answer**

- ☐ **C. Facial expressions** (e.g., grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw)
- ☐ **D. Protective body movements or postures** (e.g., bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement)
- ☐ **Z. None of these signs observed or documented** → If checked, skip to J1100, Shortness of Breath (dyspnea)

J0850. Frequency of Indicator of Pain or Possible Pain in the last 5 days

Enter Code

Frequency with which resident complains or shows evidence of pain or possible pain

1. **Indicators of pain** or possible pain observed **1 to 2 days**
2. **Indicators of pain** or possible pain observed **3 to 4 days**
3. **Indicators of pain** or possible pain observed **daily**

Other Health Conditions

J1100. Shortness of Breath (dyspnea)

↓ Check all that apply

- ☐ **A. Shortness of breath** or trouble breathing **with exertion** (e.g., walking, bathing, transferring)
- ☐ **B. Shortness of breath** or trouble breathing **when sitting at rest**

F-309 Management of Pain

Address and treat underlying cause or causes (ie better control of diabetes for diabetic neuropathy)

Development treatment plan based on whether pain is episodic, continuous or both (prn vs standing orders)

Diagnosis: Types of Pain

Nociceptive

- Somatic
- Visceral

Neuropathic

When Diagnostic Evaluation of Pain May Not Be Indicated

- ◆ The patient is at the end of life or has an end-stage condition,
- ◆ The patient has requested in an advance directive that certain diagnostic procedures not be performed,
- ◆ Identifying the cause of the pain would not change the patient's care plan, and
- ◆ The burdens of a diagnostic workup outweigh the potential benefits that would be derived from determining the reason for the pain.

F-309 Management of Pain (cont.)

Treatment plan/interventions are based on:

- Resident's needs and goals
- The source, type of pain, severity and potential for multiple sources (knee pain and abdominal pain)

A variety of treatments may need to be tried (multiple modalities may be needed)

Develop care plan with specific goals (ie pain will be maintained at a level of three or less on the pain scale within 2 weeks over 75% of the time)

F-309: Non-pharmacologic Interventions

Environmental

Physical (heat/cold/compression)

Cognitive/behavioral (ie relaxation, music, aroma therapy)

May combine with pharmacologic (might allow for lower potency/dosing)

F-309: Pharmacologic Interventions

Based on cause, location, severity

Weighs risks and benefits and considers patient/resident goals for pain relief

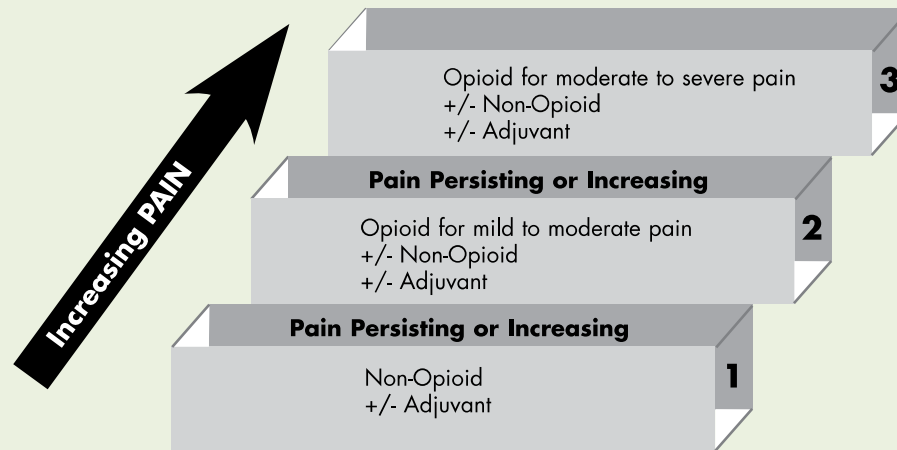
Select route

Follow an accepted approach to medication selection (WHO ladder)

Consider factors that might affect your choice of medication including comorbidities, other medications, severity, cause, and course of illness (ie EOL care and where in that continuum)

Treatment of Pain: Medication Strategies

FIGURE 1
World Health Organization Pain Relief Ladder⁴¹



F-309: Monitoring, Reassessment, and Care Plan Revision

Monitor over time to evaluate effectiveness of pain management

Use standardized assessment tools appropriate for the resident/patient

Evaluate if care plan needs to be revised

Monitoring of Pain for Individual Patients

- ◆ Every day;
- ◆ Every shift;
- ◆ Before and after administration of analgesics;
- ◆ Before, during, and after ADLs; and
- ◆ With associated procedures or therapy that may cause pain.

Pain Management: Who is Responsible (ALL IDT Members)

Nursing staff

Rehabilitative staff

Practitioners

Dietician

Social workers

Pharmacists

Administration

Patients and responsible
parties

Monitoring Pain Management at a Facility Level

Process Indicators

- ◆ Facility has adopted policies and procedures that promote a systematic, interdisciplinary, and individualized approach to pain management.
- ◆ Facility staff and affiliated professionals receive appropriate education that reflects current standards and practice in pain management.
- ◆ Patients are regularly assessed or evaluated for the presence of pain or risk factors for pain.
- ◆ Staff members have selected a pain assessment method appropriate for each patient's cognitive level.
- ◆ Scope of diagnostic workup for pain (or reasons for limiting its scope) and pain relief measures are documented in the patient's record.
- ◆ An appropriate, individualized, interdisciplinary care plan that includes stated care goals is implemented for each patient with pain.
- ◆ Environmental and other nonpharmacologic interventions are implemented to optimize function and quality of life for patients with pain.
- ◆ Analgesic medications are used and monitored appropriately in patients with pain.
- ◆ Patients prescribed NSAIDs are monitored for deterioration in cardiac, cognitive, or renal function and for the onset of GI symptoms and signs (including occult blood in the stool).
- ◆ When opioids are prescribed, a bowel regimen is implemented to prevent opioid-induced bowel dysfunction.
- ◆ During initiation of opioid therapy, a monitoring plan to address excessive sedation and respiratory depression is prepared and implemented.
- ◆ Patients with pain are assessed for depression.
- ◆ Charts include appropriate documentation of assessment, treatment, management, and outcomes.

Monitoring Pain Management at a Facility Level

Outcome Indicators

- ◆ Increases in
 - Number of patients achieving pain control goals
 - Number of patients with pain showing improvements in function and quality of life
 - Number of patients receiving scheduled pain medications

- ◆ Decreases in
 - Number of doses of PRN pain medications
 - Number of patients with severe opioid-related constipation or fecal impaction
 - Number of patients reporting pain on a daily basis

Pain Management: Medical Director Role F-501

Policies and Procedure

- Educate staff on best practices
- Review measures related to pain management
- Participate/support pain management team

Medical Staff Oversight

- Monitor staff performance in identifying, assessing, and managing pain in keeping with principles of good pain management
- Audit charts and provide feedback to practitioners
- Assess individual patients when concerns about management/appropriate prescribing in keeping with principles of good pain management

Pain Management: Practitioner Role

Assess and appropriately document pain (location, duration, severity, what improves/worsens, nature of pain)

Utilize non-pharmacologic modalities when appropriate

Follow principles of “QUALITY PRESCRIBING”

Reassess effectiveness of plan on a regular basis and document in their notes

DEPRESCRIBE

Pain management: AMDA Quality Prescribing



AMDA Quality Prescribing

Key Benefits

Key risks

Risk/Benefit Ratio

Safe Prescribing

Monitoring and Effectiveness

Deprescribing and Diversion

Key References

Pain Medication Orders: A Couple of Caveats

Complete orders only please

Beware of multiple prns-be specific

- No ranges for frequency (every 4-6 hours)
- Specify specific pain/severity if different pain meds (correlate with your pain assessment tools)
- Acetaminophen for mild pain (define)
- Oxycodone for moderate to severe pain(define)

ProPublica Nursing Home Inspect December 2015: Deficiencies Related to Pain

324,509 deficiencies overall

5.0% G level or higher

16.1% pain cited in deficiency

52,219 deficiencies with pain in citation

15.1% G level or higher

Changes in Opioid Use in the United States

From 1999 to 2010 we doubled the number of opioid prescriptions

In 2009 hydrocodone was the single most prescribed drug in the United States

Opioid analgesics are the third most common class of drugs prescribed

Cost of 8.4 billion for opioids in 2010

Limited evidence of effectiveness in chronic pain

Prescription Pain Management: Other Regulators

Federal DEA

State PDMPs (Prescription Drug Monitoring Programs)

FDA REMS (Risk Evaluation and Management Strategy) for ER/LA opioids (2012)

DEA and Prescribing Controlled Substances in Nursing Homes

Existing DEA rules see nursing homes as outpatient settings and do not see the nursing staff as agents of the prescriber like they do in hospitals

SNF prescriber must provide a signed prescription to the pharmacy before controlled substance can be dispensed or speak with pharmacist directly

Nurse can not take verbal order from physician and communicate to pharmacy

National Action Plan for Adverse Drug Event Prevention



U.S. Department of Health and Human Services
Office of Disease Prevention and Health Promotion

2014

Opioid Adverse Events

Over sedation

- Yes, you should have naloxone in your emergency box and make sure staff trained to use it

Respiratory depression

Gastrointestinal adverse effects

Opioid induced hyperalgesia

Pruritus

Opioid Adverse Events

From 1999-2010 we quadrupled the number of prescription opioid deaths which now exceeding heroin and cocaine combined

Emergency department visits have doubled since 2004

Need to balance the need for effective pain treatment in parallel with efforts to ensure safest treatment

- Therapeutic use
- Misuse/abuse

National Action Plan for Adverse Drug Reactions: 2014 Opioids

National Action Plan for Adverse Drug Events

Prescription opioid–related deaths are considered to be one of the Nation’s leading preventable public health problems.

Access to safe and effective pain care remains an important problem in the United States; efforts to minimize the burden of harms from opioids should be implemented in parallel with efforts to ensure patients suffering from pain receive the most effective and safest treatment available.

National Action Plan for Adverse Drug Events

Distinguishing overdoses that occur during the normal course of care from misuse/abuse will be important in efforts to prevent opioid ADEs.

Future surveillance efforts should capture opioid ADEs on the basis of validated process and outcome measures, differentiate opioid ADEs that occur in the normal course of care from those arising from opioid misuse/abuse, and identify ADEs occurring during transitions of care.

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**ADVERSE EVENTS IN SKILLED
NURSING FACILITIES:
NATIONAL INCIDENCE AMONG
MEDICARE BENEFICIARIES**



**Daniel R. Levinson
Inspector General**

**February 2014
OEI-06-11-00370**

OIG 2014 Report SNF Adverse Events and Temporary Harm Events

22% of Medicare beneficiaries experienced harm events during the first 35 SNF days

- 37% medication related
 - 12% medication related delirium or other change in mental status
 - 4% constipation, obstipation, ileus

11% of Medicare beneficiaries experienced temporary Harm events during the first 35 days of their SNF stay

- 43% medication related
 - 7% medication induced delirium or other changes in mental status

Eight Opioid Safety Principles for Patients and Caregivers®

- 1. Never take an opioid pain medication that is not prescribed to you**
- 2. Never adjust your own doses**
- 3. Never mix with alcohol**
- 4. Taking sleep aids or anti-anxiety medications together with opioid pain medication can be dangerous**
- 5. Always tell your healthcare provider about all medications you are taking from any source**
- 6. Keep track of when you take all medications**
- 7. Keep your medications locked in a safe place**
- 8. Dispose of any unused medications**

Other Issues in Pain Management: Prescription Opioid Abuse

Residents/Patients

Staff

Family/Visitors

TECH & SCIENCE

WHEN DRUG ADDICTS WORK IN HOSPITALS, NO ONE IS SAFE

BY **KURT EICHENWALD** ON 6/18/15 AT 6:07 AM



N

Emergency Physician Identification of a Cluster of Elder Abuse in Nursing Home Residents: July 2014 Annals of Emergency Medicine

During the next 2 days, 4 additional residents were identified by the nursing home with both a positive urine test result for opioids and symptoms of opioid toxicity. All 4 patients were evaluated in the ED and admitted to the hospital. Blood testing results were positive for high levels of morphine in all 7 patients. A follow-up investigation led to a second-degree murder charge against one of the nursing home nurses, who pled guilty to involuntary manslaughter and 6 counts of felony patient abuse.

Substance Abuse in the Elderly (Mental Health Services Administration 2008)

Not just “younger” residents

One in eight seniors seeks help for substance abuse

- 60% alcohol
- 16% heroin
- 11.4% cocaine

Happy Hour in Assisted Living? Substance Abuse Among Seniors on the Rise

Are senior living facilities equipped to provide addictions counseling to residents?

Senior living providers aim to meet the demands of today's active adult lifestyles, happy hour and cocktail parties are becoming increasingly common in independent living and assisted living facilities. These types of activities will present unique challenges should one or more residents have a history of substance abuse.

Substance Abuse: Need Facilities that Have Expertise

Jewish Home Launches First in Nation Nursing Home Based Geriatric Substance Abuse Program

NEW YORK, NY: August 13, 2014—Today, New York City's Jewish Home Lifecare, one of the country's largest and most diversified not-for-profit geriatric health and rehabilitation institutions, will launch the country's first nursing home-based recovery program for older adults dealing with alcohol and/or prescription drug addiction.

CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016



CDC Recommendations for Prescribing Opioids for Chronic Pain (Outside of Active Cancer, Palliative, and End-of-Life Care)

Determining When to Initiate or Continue Opioids for Chronic Pain

Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. If opioids are used, they should be combined with nonpharmacological therapy and nonopioid pharmacologic therapy, as appropriate.

Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks.

Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CDC Recommendations for Prescribing Opioids for Chronic Pain (Outside of Active Cancer, Palliative, and End-of-Life Care)

Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation

When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

When opioids are started, clinicians should prescribe the lowest effective dosage.

Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently.

CDC Recommendations for Prescribing Opioids for Chronic Pain (Outside of Active Cancer, Palliative, and End-of-Life Care)

Assessing Risk and Addressing Harms of Opioid Use

Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Consider offering naloxone for those at high risk for overdose.

Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose.

When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

Checklist for prescribing opioids for chronic pain

For primary care providers treating adults (18+) with chronic pain ≥ 3 months, excluding cancer, palliative, and end-of-life care

CHECKLIST

When **CONSIDERING** long-term opioid therapy

- ☐ Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- ☐ Check that non-opioid therapies tried and optimized.
- ☐ Discuss benefits and risks (eg, addiction, overdose) with patient.
- ☐ Evaluate risk of harm or misuse.
 - Discuss risk factors with patient.
 - Check prescription drug monitoring program (PDMP) data.
 - Check urine drug screen.
- ☐ Set criteria for stopping or continuing opioids.
- ☐ Assess baseline pain and function (eg, PEG scale).
- ☐ Schedule initial reassessment within 1–4 weeks.
- ☐ Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

If **RENEWING** without patient visit

- ☐ Check that return visit is scheduled ≤ 3 months from last visit.

When **REASSESSING** at return visit

Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.

- ☐ Assess pain and function (eg, PEG); compare results to baseline.
- ☐ Evaluate risk of harm or misuse:
 - Observe patient for signs of over-sedation or overdose risk.
 - If yes: Taper dose.
 - Check PDMP.
 - Check for opioid use disorder if indicated (eg, difficulty controlling use).
 - If yes: Refer for treatment.
- ☐ Check that non-opioid therapies optimized.
- ☐ Determine whether to continue, adjust, taper, or stop opioids.
- ☐ Calculate opioid dosage morphine milligram equivalent (MME).
 - If ≥ 50 MME/day total (≥ 50 mg hydrocodone; ≥ 33 mg oxycodone), increase frequency of follow-up; consider offering naloxone.
 - Avoid ≥ 90 MME/day total (≥ 90 mg hydrocodone; ≥ 60 mg oxycodone), or carefully justify; consider specialist referral.
- ☐ Schedule reassessment at regular intervals (≤ 3 months).

REFERENCE

EVIDENCE ABOUT OPIOID THERAPY

- *Benefits of long-term opioid therapy for chronic pain not well supported by evidence.*
- *Short-term benefits small to moderate for pain; inconsistent for function.*
- *Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.*

NON-OPIOID THERAPIES

Use alone or combined with opioids, as indicated:

- Non-opioid medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants).
- Physical treatments (eg, exercise therapy, weight loss).
- Behavioral treatment (eg, CBT).
- Procedures (eg, intra-articular corticosteroids).

EVALUATING RISK OF HARM OR MISUSE

Known risk factors include:

- Illegal drug use; prescription drug use for nonmedical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (eg, depression, anxiety).
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.

Urine drug testing: Check to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.

Prescription drug monitoring program (PDMP):

Check for opioids or benzodiazepines from other sources.

ASSESSING PAIN & FUNCTION USING PEG SCALE

PEG score = average 3 individual question scores (30% improvement from baseline is clinically meaningful)

Q1: *What number from 0–10 best describes your **pain** in the past week?*

0 = “no pain”, 10 = “worst you can imagine”

Q2: *What number from 0–10 describes how, during the past week, pain has interfered with your **enjoyment of life**?*

0 = “not at all”, 10 = “complete interference”

Q3: *What number from 0–10 describes how, during the past week, pain has interfered with your **general activity**?*

0 = “not at all”, 10 = “complete interference”



TO LEARN MORE

WWW.CDC.GOV/DRUGOVERDOSE/PREScribing/GUIDELINE

National Pain Strategy



The banner features the title "National Pain Strategy" in a large, blue, serif font. To the left of the title is a logo consisting of five overlapping circles in shades of blue, green, and orange. Below the title, the text "The Office of the Assistant Secretary for Health at the U.S. Department of Health and Human Services today released a National Pain Strategy." is written in a black, sans-serif font. To the left of this text is the official seal of the U.S. Department of Health and Human Services. To the right of the text is a blue button with the text "Now available... FINAL REPORT" in white. On the right side of the banner is a large image of a doctor's hands examining a patient's arm. Two smaller inset images are overlaid on this: one of a woman holding her head in pain and another of a man holding his neck in pain.

National Pain Strategy

The Office of the Assistant Secretary for Health at the U.S. Department of Health and Human Services today released a National Pain Strategy.

Now available...
FINAL REPORT

!

!

March 18, 2016

National Pain Strategy outlines actions for improving pain care in America

Plan seeks to reduce the burden and prevalence of pain and to improve the treatment of pain

DATE: September 27, 2012

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: F tag 309—Quality of Care- Advance Copy

Memorandum Summary

- **Revisions:** Revisions have been made to Guidance to Surveyors at F tag 309 in Appendix PP of SOM.
- **Power Points:** Power Point training material with speaker notes for Centers for Medicare & Medicaid Services (CMS) Regional Offices (ROs) and State Survey Agencies (SAs) to be used to train surveyors on this revision are provided.

Pain Management in End Of Life Care for the Nursing Home Resident

Thorough assessment and frequent re-assessment for presence and cause (may be multiple types of pain present)

Use medications regularly for established pain (same basic principles)

Predict the adverse events (constipation)

Availability of medications

Medicate terminal restlessness

Work with hospice if benefit chosen

The Goldilocks of Medication Management at the End-of-Life: Not Too Little, Not Too Much, Just Right!

Presented by **Mary Lynn McPherson**, PharmD, MA, BCPS, CPE

Professor and Vice Chair Department of Pharmacy Practice and Science
University of Maryland School of Pharmacy

References:

Keith H. Berge,a, Kevin R. Dillon,b Karen M. Sikkink,b Timothy K. Taylor,c and William L. Laniera .Mayo Clin Proc. (2012) ***Diversion of Drugs Within Health Care Facilities, a Multiple-Victim Crime: Patterns of Diversion, Scope, Consequences, Detection, and Prevention***. Jul; 87(7): 674–682. doi: 10.1016/j.mayocp.2012.03.013. PMCID: PMC3538481

Age Ageing (2013). ***Guidance on the Management of Pain in Older People***. (2013) 42 (suppl 1): i1-i57 doi:10.1093/ageing/afs200

VA/DOD.(2010). Veterans Administration /DoD ***CLINICAL PRACTICE GUIDELINE FOR MANAGEMENT OF OPIOID THERAPY FOR CHRONIC PAIN***. http://www.healthquality.va.gov/guidelines/Pain/cot/COT_312_Full-er.pdf. 160 pages used by VAH

Draft CDC Guideline for Prescribing Opioids for Chronic Pain. <http://www.cdc.gov/drugoverdose/prescribing/guideline.html>
Still in draft format but good materials.

AGS Panel on Persistent Pain in Older Persons. ***The Management of Persistent Pain in Older Persons***. J Am Geriatr Soc 2002; 50: S205-224.

American Geriatrics Society (AGS) Panel on the Pharmacological Management of Persistent Pain in Older Persons. ***Pharmacological Management of Persistent Pain in Older Persons***. J Am Geriatr Soc 2009; 57: 1331-1346.

AMDA-The Society for Post-Acute and LTC Medicine. ***Pain Management in the Long Term Care Setting Clinical Practice Guideline***. Columbia, MD:AMDA 2012.



YOUNGER ADULTS IN LONG-TERM CARE

Joint Provider Surveyor Training Grand Rapids, MI

September 20, 2016

MARY MULLIGAN, RN, BSN, MA, CDONA/LTC, CLNC

ACTING DIRECTOR - CLINICAL AFFAIRS

**AMDA – THE SOCIETY FOR POST-ACUTE & LONG-TERM
CARE MEDICINE**

CMP Grant

AMDA – The Society for Post-Acute and Long-Term Care Medicine was awarded a 3 year 1.624M CMP grant in 2014.

**CMS Region IV Partners:
Alabama, Florida, Georgia, Kentucky,
Mississippi and South Carolina**



THE SOCIETY
FOR POST-ACUTE AND
LONG-TERM
CARE MEDICINE™





Face-to-Face



Online



CoP

Three Pillar Approach to Training

Objectives

- 1. To understand the demographic trend and the needs of the younger adult (YA) in LTC**
- 2. To relate behavioral problems to cognitive issues**
- 3. To understand resident rights and facility responsibilities**
- 4. To learn how facilities can satisfy regulatory requirements while meeting the needs of the YA**



Individual Perspectives

Who am I?

Scope of the Problem

Commitment for the Long-term

Who is the Younger Adult?

For purposes of the YA training, AMDA defines younger adults as those aged 18 – 64 years.

The fastest growing population in LTC facilities are adults ages 31- 64 years ⁽¹⁾

1. NPR Special Series: Home or Nursing Home: A New Nursing Home Population: The Young. Available at: <http://www.npr.org/2010/12/09/131912529/a-new-nursing-home-population-the-young>. Accessed 01/21/13.

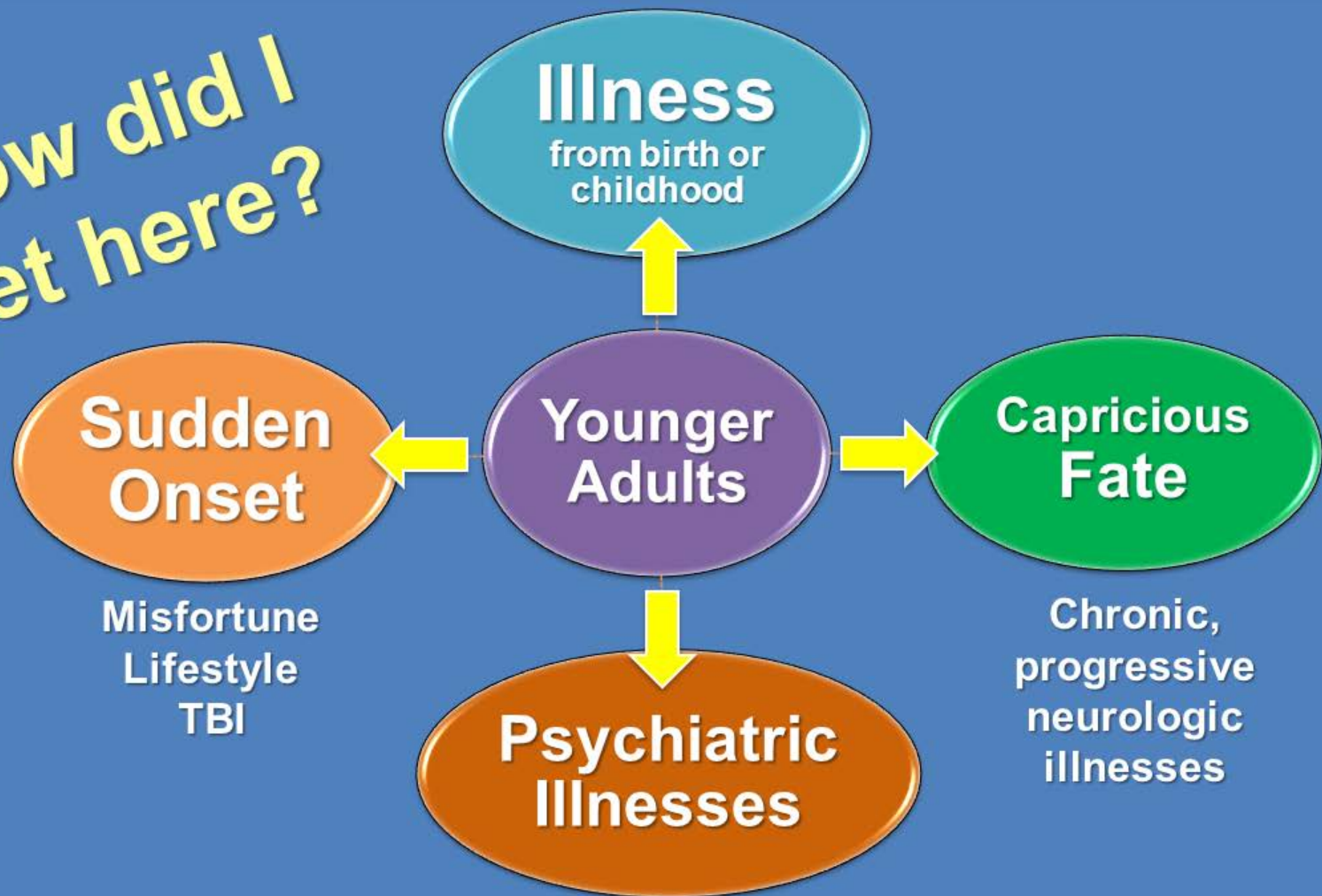
Who I am...



...may
depend on
how I got “sick”



**How did I
get here?**



Did you know that...

- Younger adults ages 31-64 years of age are the fastest growing population in long-term care settings
- Long-term care is no longer synonymous with “geriatric care”
- Almost 15% of long-term care residents are < 65 years of age

- Sexuality
- Technology
- Homelessness
- Mental illness
- Birth control
- Social media
- School attendance
- Residents as parents
- Night Owls

Younger Adults in Long-term Care



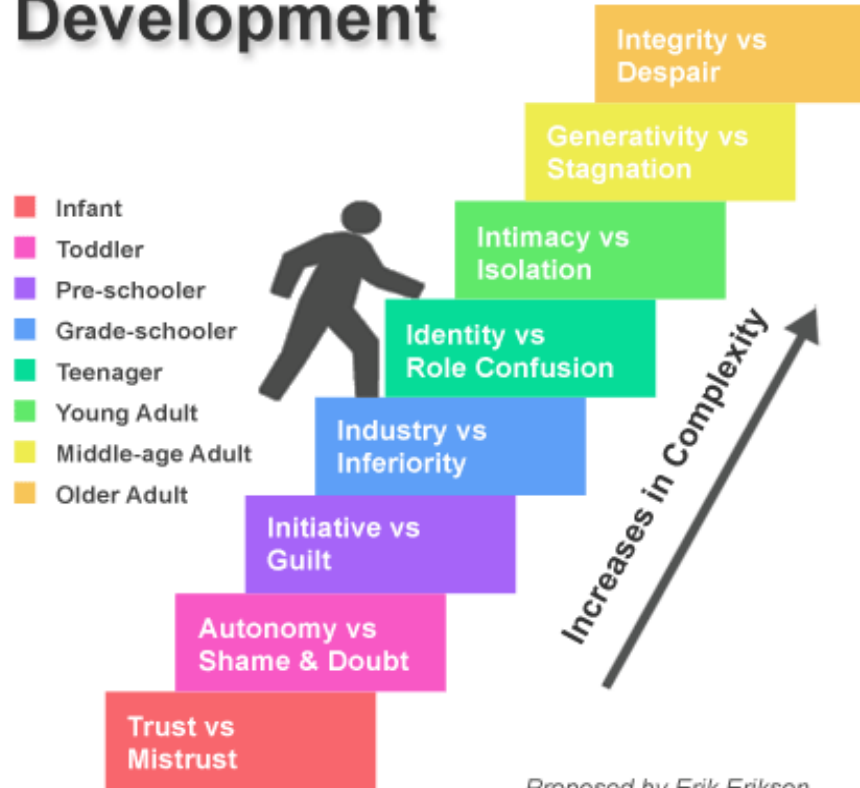
**It's not just
when you were born...**

It's where you are in life...



Erikson's Developmental Stages

Stages of Psychosocial Development



Proposed by Erik Erikson

Who am I?

In addition to different cohorts and different stages in overall development, younger residents may have less mature psychological coping skills.

This presents both a challenge and an opportunity for growth.

Stages of Development



- ***Intimacy vs Isolation***
Young Adulthood (19-40 years)
- ***Generativity vs Stagnation***
Middle Adulthood (40-65 years)



Meeting the Needs of Younger Adults

- **Clinical, Psychosocial & Behavioral Concerns**
- **Financial Concerns**

Clinical, Psychosocial & Behavioral Concerns

- Geriatricians lack experience with younger adults
- Staff lack experience and often interest in caring for younger adults
- Palliative care/end-of-life care
- Sexually inappropriate behavior
- Children or parents as decision-makers
- Different life stages, expectations and hopes

Financial Concerns



- Head in the bed for a long time with low reimbursement
- Possible litigation issues due to risky behaviors
- Resource-intensive and expensive care



More Barriers to Care

- Practical Issues
- Staffing Concerns
- Reputation of the Facility



YOUNGER ADULTS IN LONG-TERM CARE

Anticipate Cognitive Problems

Conditions That Affect Cognition

- AIDS
- Drugs/ETOH
- Psychiatric illness
- Diabetes
- Dementia
- Developmental Delay
- Head Injury/Trauma
- Neurologic Illnesses



Why Assess Cognitive Ability?

Cognitive Ability

- Impacts behavioral management
- Impacts facility actions to determine which decisions a person can safely make
- Impacts ability to provide excellent care

Capacity

In long-term care, almost all patients have some cognitive decline and many have moderate to severe dementia

Patients who are “in-between” pose the greatest challenges



Development of Facility Policies and Individual Plans of Care



Regulations

How does the facility comply with regulations while preserving resident rights?



F 155 Right to Refuse Treatment

F 248 Activities Program

F 329 Unnecessary Drugs

F 155 Right to Refuse Treatment

Resident rights vs facility responsibility

Does the patient with competence and capacity have the right to refuse treatment knowing the outcome will be a negative one, possibly shortening their life?



...you want me to go to a wound care specialist because you think they might help me.

I don't want to go.

I have had this wound a long time and I don't care if I die with this wound!
It isn't getting better with no specialist and I will never have surgery.

You guys keep asking me and I keep telling you the same thing—I am fine like it is.

Just cover it up and put my pants on.

I have to go sometime and I want to focus on living the way I want to.



I know you said I could get an infection and die - well, I am not sure you are right as I have had it a long time and I am not dead yet - but if I die, well, that's the way it is.

F 248 Activities Program

Activities Programs

- Current activities not geared for young adults
- Young adults requesting iPads and computers
- Wish to engage with other younger adults whereas older adults may be content to be on their own at given times



**Leaving unaccompanied –
Can we stop them?**



Desired Activity of a Young Adult

YA with capacity confined to motorized wheelchair wants to go out with his friends to the bar on the weekend.



Is This True?

The YA exhibits capacity and competence, executive function, judgment, motivation, reasoning, memory, physical skills upper body and social skills per psychological and medical assessment.

Facility Role and Responsibility

*Do we have the
authority
to stop them?*



F 329 Use of Unnecessary Drugs

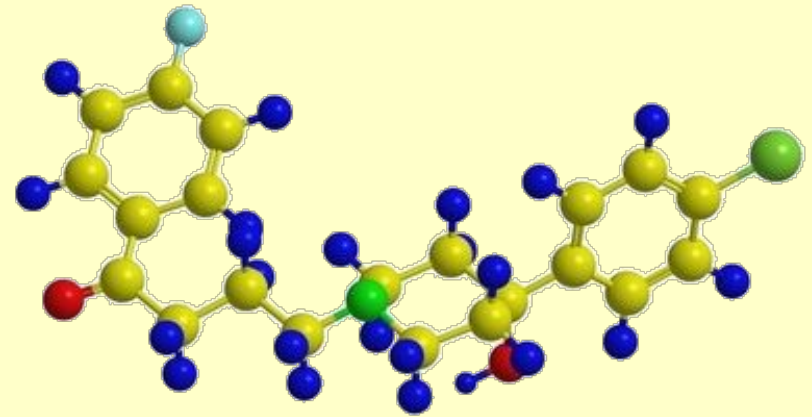
Antipsychotics

A high percentage of younger adults are on anti-psychotics for schizophrenia, schizo-affective disorder and other mental health diagnoses.

How does this affect antipsychotic reduction in a facility where these medications are necessary due to the increased rate of mental illness in this population?

Necessary Antipsychotics for the Younger Adult

Does the use of antipsychotics in this population need to be explored by CMS on a more granular level?



Use of Psychoactive Medication and Mental Status 2014 ⁽²⁾

	% of Anti-Psychotic Medications	% with Psychiatric Diagnosis	% with Behavior Symptoms	% of Behavior Symptoms Receiving Behavior Management
UNITED STATES	22.02	31.56	23.71	66.52
ALABAMA	24.92	34.32	21.87	75.46
FLORIDA	21.59	30.87	22.11	79.24
GEORGIA	23.71	35.81	28.73	51.87
KENTUCKY	22.34	35.21	23.49	73.67
MISSISSIPPI	26.00	41.72	23.44	44.62
SOUTH CAROLINA	18.46	29.32	25.00	70.29

2. Nursing Home Statistical Yearbook, 2014. Cowles Research Group. Available at: <http://www.longtermcareinfo.com/publications/nursing-home-statistical-yearbook.php>.

Extra Needs

- Due to the reality of having longer stays in LTC, the YA may have a more difficult adjustment to illness, and may need extra psychological support.
- They may require access to support groups or organizations for their particular illness.



There but for fortune go you and I

Phil Ochs – American Folk singer



Thank You

Questions?

Recruiting & Retaining CNAs in a Changing Labor Market



PHI

Quality Care
THROUGH
Quality Jobs

About PHI—Quality Care Through Quality Jobs

PHI works with all LTSS stakeholders to improve the lives of people who need home or residential care by improving the lives of the workers who provide that care.



Public Policies & Workplace Practices



What is Your Annual CNA Turnover Rate?

Total # of CNAs employed in 2015 - # of CNA positions
of CNA positions

- 0-15%
- 15-25%
- 25-50%
- >50%

What to Expect in this Session....

#1

You will have an understanding of the impact of current CNA demographic data on quality of care and quality of jobs.



What to Expect in this Session

#2

Learn how one Michigan nursing home is systemically addressing recruitment and retention



What to Expect in this Session

#3

Learn about evidence-based interventions that improve retention rates by building a culture of “quality care through quality jobs”



#1: The Demographics



Who are Michigan DCWs?

- 53% have some college or a degree
- 87% are women
- 27% are African-Americans
- 7% are foreign-born
- 47% rely on some



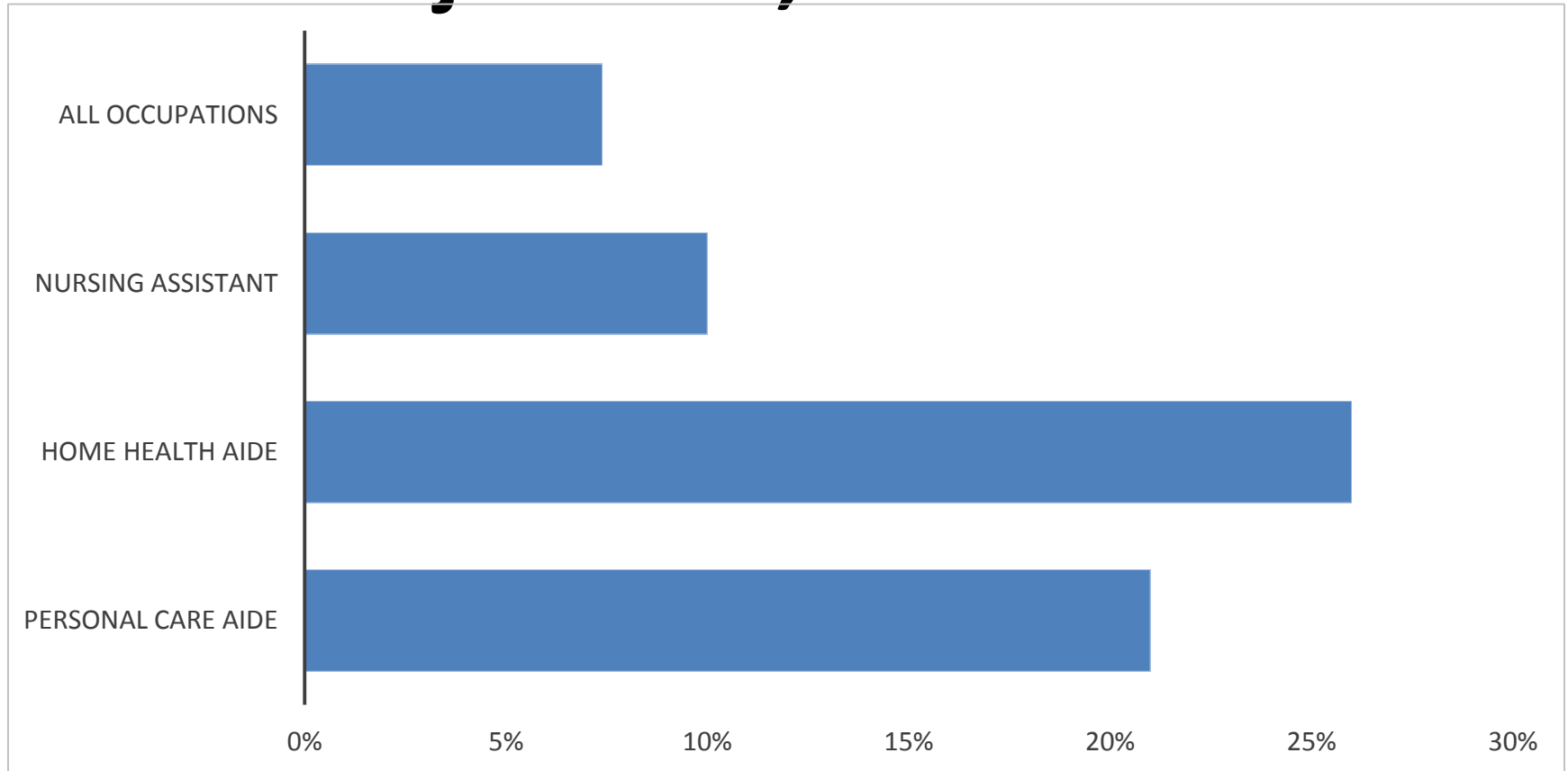
form of public benefits—Medicaid, food stamps, Medicare, child care subsidies

Source: PHI Michigan, www.PHInationa.org

Current MI CNA Registry Data

- 52,541 active CNAs are in the registry, lapsed CNAs on the registry 161,950
- Number who took the MI CNA test—10,036
- Number who passed the MI CNA test—8,450
- 28,929 CNAs needed to recertify last year
- 18,424 CNAs actually did recertify last year
- 63% retention rate of those eligible to be a CNA in Michigan at recertification

Michigan: Occupational Growth Projections, 2014-2024



WalMart's Compensation

- All entry jobs start at \$10 an hour as of 2/2016
- All staff (full and part-time) earn paid time off, no waiting period to use
- Average *current* full-time wage for this retailer is \$13.38 an hour; for part-time is \$10.58 per hour.
- Carryover PTO both sick and vacation; pays out amounts over carryover in February
- Company contributes to 401K for all staff

National Annual Nursing Home Turnover Rates

	2012 Turnover	% change from 2011
All Employees	43.9	+5.7
Direct Care Staff	50.0	+6.0
RN	50.0	+6.0
LPN	36.4	+7.5
CNA	51.5	+2.6

http://www.ahcancal.org/research_data/staffing/Documents/2012_Staffing_Report.pdf

Making the Case for Quality Jobs

Lowest areas of CNA satisfaction are comparison of pay, assistance alleviating job stress, and care/concern of management

- National Research Corporation, 2012



Top Drivers of Nursing Home Employee Satisfaction...

- Wages and Benefits
- Job Demands (measured by ratio of nursing assistant hours per resident day)
- Feeling Respected
- Feeling Valued
- Relationship with Supervisor

<http://gerontologist.oxfordjournals.org/content/49/5/611.long>

#3: Evidence-based strategies

Train supervisors

- Skills to be learned
- Relationships with accountability
- Addresses why people leave

Peer Mentors

- A clear, defined purpose
- Specific skills training
- Monetary recognition

Retention Specialist

- Linkages to services
- Building skills
- The investment saves money

#3: Evidence-based strategies

Wages and Benefits

- Competition is no longer limited to health care
- You have to be competitive

Recruiting Strategies

- Fix your turnover FIRST
- Advertise for the what you want
- Change where and how you recruit

Why Staff Satisfaction Matters

High Employee Satisfaction is linked to:

- Higher 5 star rating
- Higher resident and family satisfaction
- Improved care outcomes
- Fewer deficiencies
- Higher occupancy rates

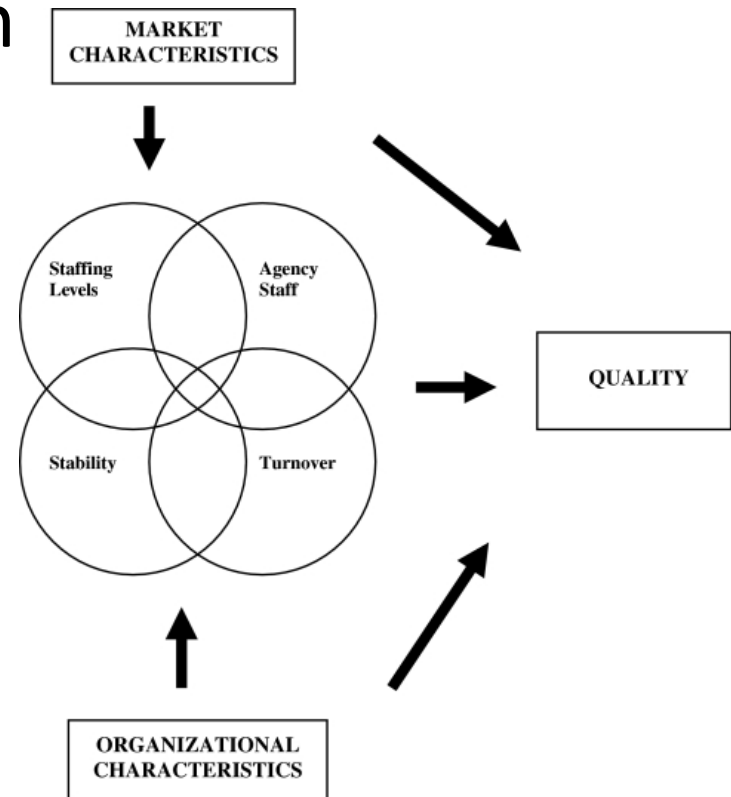
<http://www.nationalresearch.com/uploads/National-Reports/2013NationalResearchReport.pdf>

Making the Case for Quality Jobs

When staff satisfaction is high

- Fewer resident falls
- Fewer pressure ulcers
- Lower use of catheters
- Reduced staff turnover
- Reduced absenteeism

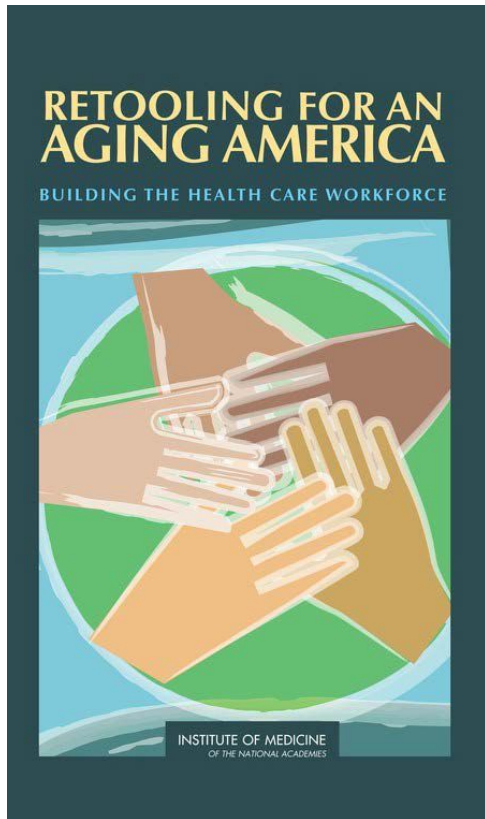
– *Nicholas Castle, 2007*



#3: Evidence Based Practices

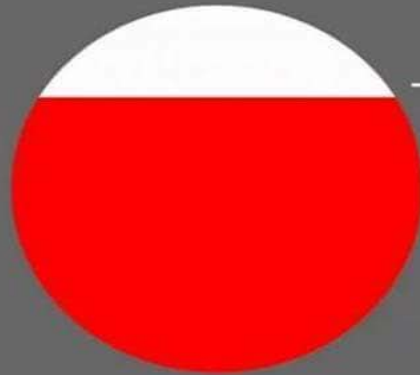


IOM on Supervision



- Positive Supervision can greatly increase DCWs sense of value, job satisfaction, and intent to stay
- RNs and LPNs supervise CNAs yet few nurses have been afforded adequate supervisory training

WHY PEOPLE CHANGE JOBS



75%

of workers who
voluntarily left their jobs
did so because of their
bosses and not the
position itself



People don't quit jobs,
they quit bosses.



Source:

<http://www.gallup.com/businessjournal/106912/turning-around-your-turnover-problem.aspx>



Coaching
Supervision
is a
RELATIONAL
approach

				S					SKILL DEVELOPMENT							
				O												
P	R	O	B	L	E	M										
				V				C								
				I	N	T	E	R	P	E	R	S	O	N	A	L
				N				I								
				G				T								
						T	H	I	N	K	I	N	G			
								C								
C	O	M	M	U	N	I	C	A	T	I	O	N				
								L								

Coaching Supervision Outcomes

- Improved employee satisfaction
- Improved employee retention
- Improved clinical outcomes
- Decreased time spent managing complaints
- Decreased employee absenteeism
- Greater decision making between the resident and his/her CNA

Peer Mentoring: Compensation, Opportunity and Support



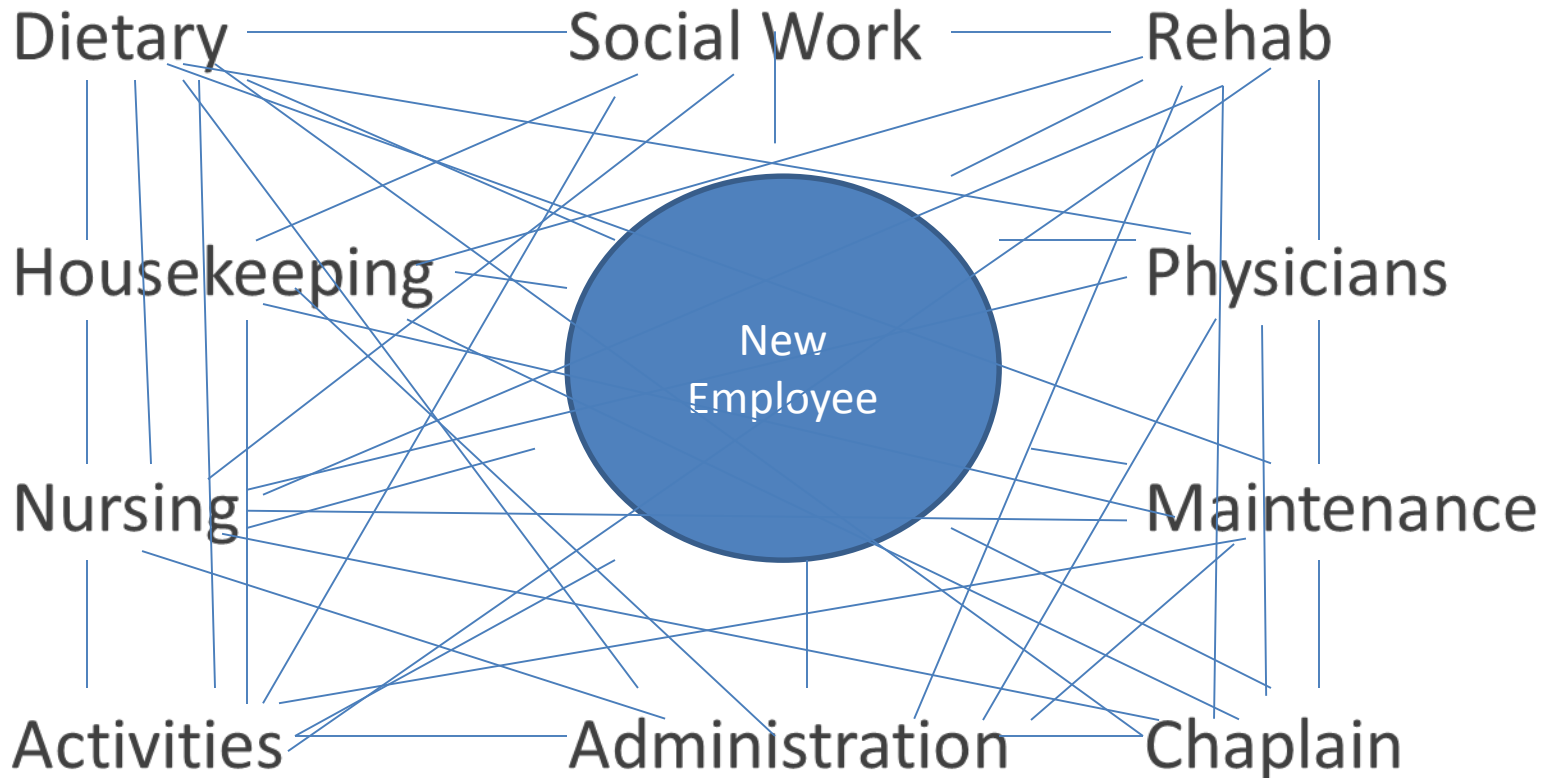
Why Mentoring

Types of Issues Mentees Presented to Mentors:

- Working relationships
- Relieving Stress/Burnout
- Care
- Working Conditions
- Communication

[http://phinational.org/sites/phinational.org/files/clearinghouse/WA Preliminary Peer Mentor Program Analysis.pdf](http://phinational.org/sites/phinational.org/files/clearinghouse/WA_Preliminary_Peer_Mentor_Program_Analysis.pdf)

Relationships Are Complex



Peer Mentoring Program

- New employee is paired with experienced, trained mentor
- Mentor builds immediate and ongoing relationship
- Mentor provides support, guidance, and sense of safety
- This strategy improves CNA retention by as much as 50%

Mentoring Do's and Don'ts

DO	DO NOT DO THIS
✓ Openly post defined position	× Hand pick mentors
✓ Provide mentor with training and train the rest of the organization	× Assume experience is adequate prep for role OR that buy in is automatic
✓ Provide mentors support	× Underestimate program supports
✓ Give pay increase	× Expect to “do more for same pay”
✓ Mentor on the assignment the employee will have	× Teach employee the mentor's assignment

Retention Specialist: How Do We Help Employees to Stay Employed?



*With known supports
and connection to
community resources*

OPEN

Mission and Vision of OPEN

Mission: To support the collaborative approach to enhancing the retention, recruitment and growth of entry-level employees in the health field.

Vision: To have a diverse, qualified and stable healthcare workforce where employees reach their full potential.

Reasons Why Employees Came to OPEN Retention Specialist

attendance
transportation
housing
finances
depression
family
disability
counseling
time management

Statistics for Year 1 of OPEN

April 2004 – March 2005

- Employees Served for Support: 64
- Employees Trained: 132
- Total Served: 196



OPEN Year 1 Cost savings

- Training Cost:
\$100.00-\$1564.00 per
person \$66,589.00 total

- Interventions:
\$3,000.00 per person
\$159,000.00 total

*based on 83% retention rate

Total \$225,589.00

- Employers Contributions:
\$42,250.00/year

- Saved:
\$183,339.00

- **Grand Total Savings
per employer :
\$36,667.80**

OPEN Year 2 Cost Savings

- Training Cost:
\$100.00-\$1599.00 per
person \$56,124.96 total

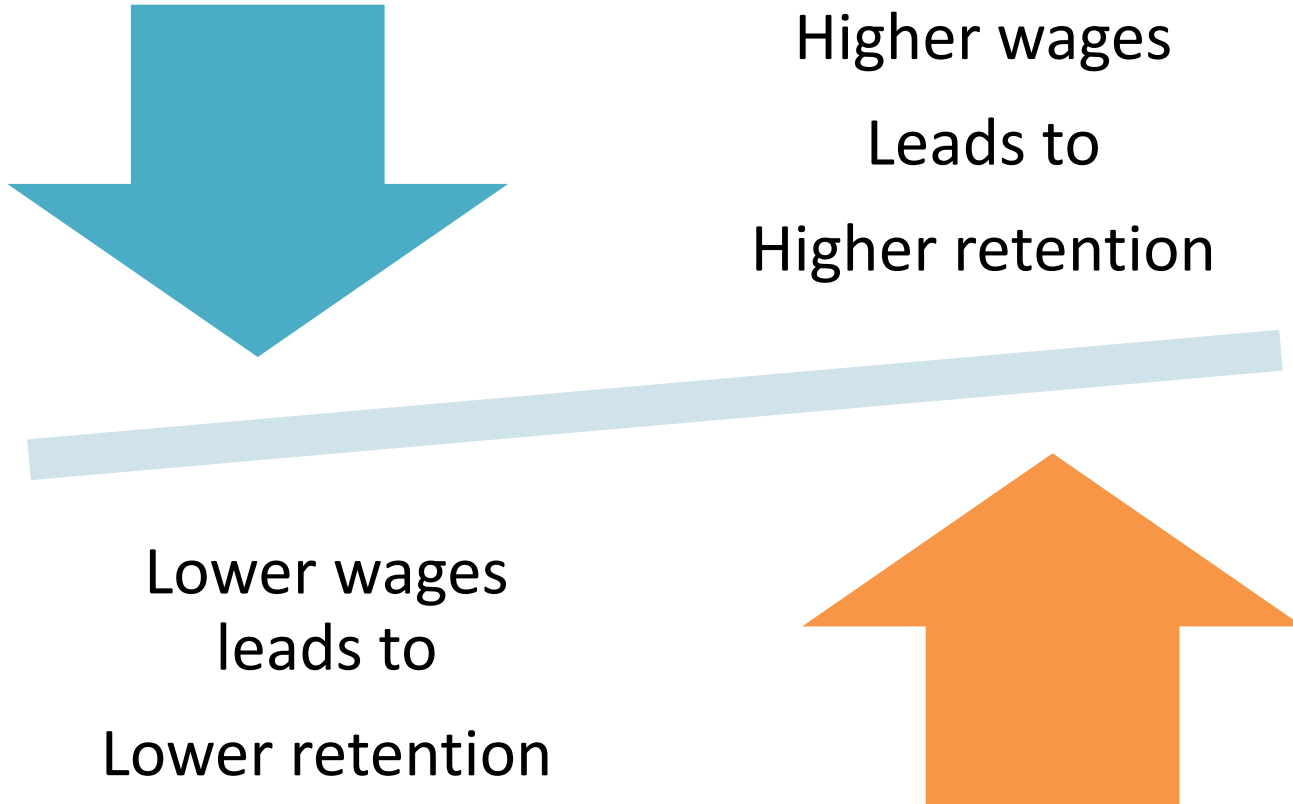
- Interventions:
\$3,000.00 per person
\$378,000.00 total

*Based on 83% retention rate

Total \$434,124.96

- Employers Contributions:
\$48,250.00/year
- Saved:
\$385,874.96
- **Grand Total Savings
per employer :
\$48,234.37**

Essential Element: Better Compensation



Recruit NEW People—the Last Step

- Plug the leaking bucket—improve your retention **FIRST**
- We have to stop sharing the same pool of workers within your community; your new hire is someone else's turnover!
- Change your outreach to attract new people to CNA work

Be Intentional and Look for New CNAs When You are Served



Questions



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www.PHInational.org

PHI

Quality Care
THROUGH
Quality Jobs

Dialysis in Long Term Care

Jessica Harback, RN, BSN
Manager, DASH Section

James D. Scott, PE
Manager, HFES Section



State Agency



- Department of Licensing and Regulatory Affairs (LARA)
 - Bureau of Community and Health Systems
 - Federal Survey and Certification Division
- Federal Survey and Certification Division has two subsets
 - Long Term Care – surveys nursing homes
 - Non-Long Term Care (NLTC) – surveys various other providers including ESRD facilities

Federal Survey & Certification Division

- Two NLTC sections:
 - Specialized Health Services
 - DASH
- Dialysis, Ambulatory Surgery Center, & Hospitals (DASH) Section
 - Team of 10 surveyors
 - Cover entire State of Michigan



DASH Survey Team



Separate CMS Regulations

- The Centers for Medicare & Medicaid Services (CMS) have established a regulation set for nursing homes seeking federal certification
 - 42 CFR 483
- Separately, CMS has a regulation set for those seeking federal certification to provide dialysis for End Stage Renal Disease (ESRD) patients
 - 42 CFR Parts 405, 410, 413, 414, 488, and 494, Conditions for Coverage for End-Stage Renal Disease Facilities



ESRD Surveys

- ESRD recertification surveys are performed an average of 3.5 years unless otherwise indicated by CMS
 - CMS sets our workload using a Tier system
 - Initial certifications are Tier 3 (lowest priority)
- Complaint surveys



ESRD Surveys

- If the ESRD facility provides home dialysis services onsite in a LTC facility, the team must visit the LTC facility to conduct additional investigations (T. Hamilton, S&C:04-24, March 19, 2004)
- Applies to both recertification and complaint surveys



How to become certified to provide dialysis in LTC?

- At present there are two ways providers are seeking certification
 1. Home program
 2. Freestanding ESRD inside the nursing home
- Home Program is most common
- While an ESRD facility may only opt to provide one service, i.e., home dialysis training, the facility must comply with ALL applicable Conditions for Coverage (CfC), which include ALL ESRD CfCs with two exceptions
 - Renal transplant centers (405.2170 and 405.2171)
 - Special purpose dialysis facilities (405.2164)
 - Vacation camps (locations that serve ESRD patients temporarily)
 - Facilities established to serve ESRD patients under emergency circumstances



CFC 42 CFR
§494.100
Condition:
Care at Home

- Home dialysis is intended to be self-dialysis performed by the patient and/or with the assistance of other individuals (T. Hamilton, S&C:04-24, March 19, 2004)
 - Challenge to apply regulations for the home program to dialysis in the LTC setting
 - We have found that dialysis being performed in the nursing homes is similar to an In-Center Hemodialysis Clinic setting
 - Multiple patients/residents dialyze at the same time
 - ESRD provider have their staff onsite



Home Dialysis



In Center Hemodialysis



Physical Environment Requirements for LTC facility

- What facilities must be provided to perform dialysis in a Long Term Care Facility?



Public Health Code

Act 368 of 1978
Article 17
Part 201

- 333.20145 Construction permit; certificate of need as condition of issuance; rules; information required for project not requiring certificate of need; public information; review and approval of architectural plans and narrative; rules; waiver; fee; "capital expenditure" defined. Sec. 20145.
- (1) ***Before contracting for and initiating a construction project involving new construction, additions, modernizations, or conversions of a health facility or agency*** with a capital expenditure of \$1,000,000.00 or more, a person shall obtain a construction permit from the department. The department shall not issue the permit under this subsection unless the applicant holds a valid certificate of need if a certificate of need is required for the project under part 222.
- (2) To protect the public health, safety, and welfare, ***the department may promulgate rules to require construction permits for projects other than those described in subsection (1)*** and the submission of plans for other construction projects to expand or change service areas and services provided.



Minimum Design Standards

- 333.20145 Construction permit; certificate of need as condition of issuance; rules; information required for project not requiring certificate of need; public information; review and approval of architectural plans and narrative; rules; waiver; fee; "capital expenditure" defined.
- Sec. 20145. (6) The review and approval of architectural plans and narrative shall require that the proposed construction project is designed and constructed in accord with applicable statutory and other regulatory requirements. In performing a construction permit review for a health facility or agency under this section, ***the department shall, at a minimum, apply the standards contained in the document entitled "Minimum Design Standards for Health Care Facilities in Michigan" published by the department and dated July 2007.*** The standards are incorporated by reference for purposes of this subsection. The department may promulgate rules that are more stringent than the standards if necessary to protect the public health, safety, and welfare.



Nursing Home Licensing Rules

- **R 325.20213 Construction and major alterations of nursing homes.**
- Rule 213. (1) A home shall not contract for or initiate either of the following projects without first obtaining a construction permit from the department:
- (a) A project for which a construction permit is required by section 20145 of the code.
- (b) A project to expand or change service areas for services provided which involves major alterations.



Nursing Home Licensing Rules

- **Rule 213 (2) The owner or governing body of a home or proposed home shall submit plans.**
- for projects described in subrule (1) of this rule to the department for review and
- approval before contracting for and initiating such projects. The department shall
- approve the plans if it determines that the project is designed and constructed in accord
- with applicable statutory and regulatory requirements.



Nursing Home Licensing Rules

- Rule 213 (3) A major alteration is deemed to be any ***extensive structural alteration*** of an existing building area involving ***significant changes in the interior configurations or intended use*** by the moving of partitions of a number of rooms and involving an ***expenditure in an amount in excess of \$25,000.00***. Removal of a partition between 2 adjacent rooms to provide additional room space is not deemed to be a major alteration, unless it exceeds \$25,000.00 in cost or unless multiple changes are to be made for a changed use of an entire wing or area and extensive plumbing or electrical wiring changes are required.



Minimum Design Standards

Michigan Department of Community Health

THE 2007 MINIMUM DESIGN STANDARDS FOR HEALTH CARE FACILITIES IN MICHIGAN



BRHS-PS-887 (Formal Only Rev. 04/05/10)
Authority: P.A. 266 of 1970, as amended

The Michigan Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs. You may make your needs known to this agency under the Americans with Disabilities Act if you need assistance with reading, writing, hearing, etc.

7.14 Renal Dialysis Unit (Acute and Chronic)

Regulation Text (see Appendix A)

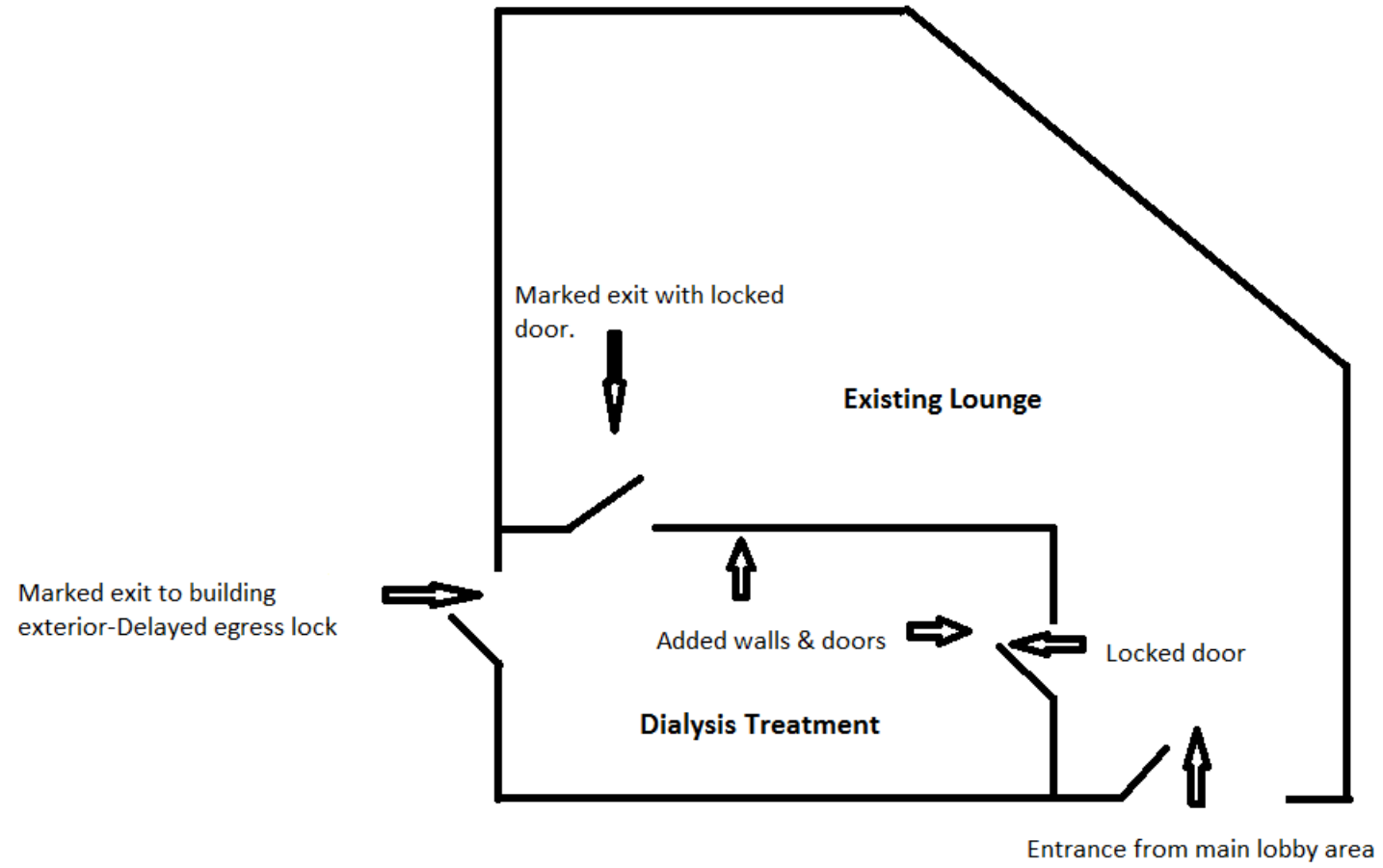
- **A.7.14** *The unit should comply with the guidelines of the Association for Advancement of Medical Instrumentation (AAMI) and the requirements of the CMS as found in 42 CFR section 405.2102 and following for End Stage Renal Disease (ESRD).*
- **A.7.14.A2** *The location should offer convenient access for outpatients. Accessibility to the unit from parking and public transportation should be a consideration.*
- **A.7.14.A3** *Space and equipment should be provided as necessary to accommodate the operational narrative, which may include acute (inpatient services) and chronic cases, home treatment and kidney reuse facilities. Inpatient services (acute) may be performed in critical care and designated areas in the hospital, with appropriate utilities.*

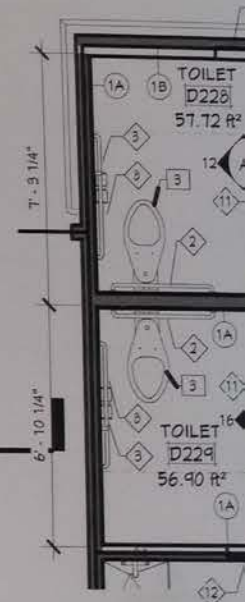


Life Safety Concerns

- Blocked or Locked Exits
- No Audible or Visible Alarm
- Storage within 18 inches of sprinkler heads







7 REST
A2.2 $1/4" = 1'-0"$





LSC Requirements – K 22

- On February 17, 2016 at approximately 1:20 AM, the following observation was made and witnessed by the Maintenance Director that the rear door from the Dialysis Treatment Room/Lounge did not have a sign installed indicating that it was a 15 second delayed egress door. The sign shall be readily visible, durable sign letters not less than 1 inch high and not less than 1/8 inch in stroke width on a contrasting background that reads as follows: **PUSH UNTIL ALARM SOUNDS
DOOR CAN BE OPENED IN 15 SECONDS.**



LSC Requirements – K 38

- 3. Observed that the secondary exit door from the Lounge leading through the Dialysis Treatment Room had a key lock installed on the door from the exit egress side.

LSC Requirements – K 51

- Based on observation and interview, the facility failed to provide fire alarm system in accordance with LSC Sections 19.3.4 and 9.6. This deficient practice could potentially affect 6 occupants of the facility in the event of a fire where detection or notification were delayed.
- Findings Include:
- On February 17, 2016, 2015 at approximately 1:17 PM, the following observation was made and witnessed by the Maintenance Director that the Dialysis Treatment Room located in the 1st floor Lounge did not have a required fire alarm notification device installed.



ESRD Survey Process for LTC visit

- Surveyor(s) will present onsite to LTC location(s) where the ESRD facility has patients
- Will need a workspace
- Will need to immediately begin observations of dialysis being performed



ESRD Survey Process

- Primary focus of surveyors is to assess compliance with CfCs for ESRD provider
- Perform observations of patients/residents undergoing dialysis
- Information to provide the ESRD surveyor:
 - The contractual arrangements (written coordination agreement) between the ESRD facility, the LTC facility, and the Durable Medical Equipment (DME) supplier



ESRD Survey Process cont.

- The number of residents who are dialyzing
 - Are they dialyzing as a skilled nursing facility's (SNF) or nursing facility's (NF) resident?
 - How long have they been residents of the LTC facility?
 - Are they on hemodialysis or peritoneal dialysis?
 - What DME supplier is used (if applicable)?
- Where and when are the residents dialyzing
 - In a common room or bedroom
 - Days/hours dialysis is performed
- Have all of this information ready in a binder
 - "Survey Ready" binder
 - Update monthly

ESRD Survey Process cont.

- Written Coordination Agreement
 - Signed by both ESRD facility and LTC facility
 - Must be reviewed annually
 - Must include information on financial aspects and patient care responsibilities among the ESRD facility, the LTC facility, and the DME supplier (if applicable).



ESRD Survey Process cont.

- Written Coordination Agreement (Cont)
 - Delineates respective responsibilities and accountability for:
 - Routine & emergency care
 - Where will patients be sent in event of emergency
 - Care planning
 - Communication
 - ESRD facility staff communicates patient care issues with LTC staff
- Clear lines of responsibility and accountability between ESRD and LTC facilities that safeguard the health and safety of the patients

ESRD Survey Process cont.

- In addition to infection control observations look for evidence of collaboration between ESRD and LTC facilities to investigate, control, and prevent infections
- LTC facility's infection control policies are to be reviewed by the Medical Director of the ESRD facility
- Staff providing dialysis follow appropriate hand hygiene, use of gloves
- Items used for dialysis are dedicated to single use or appropriately cleaned and disinfected



ESRD Survey Process cont.

- ESRD provider must ensure one or more licensed health care professional experienced in dialysis is on duty to oversee ESRD patient care whenever patients are undergoing dialysis
 - Experienced in or trained by the ESRD facility to
 - Perform assessments
 - Observe patients pre and post treatment
 - Respond to emergency situations relative to dialysis treatments
 - Administer any necessary intravenous, intradialytic, and intramuscular medications in accordance with all Federal and State requirements
- If LTC facility has contracted staff to the ESRD facility please be prepared to provide documentation related to training as indicated above



ESRD Survey Process cont.

- Medical Records
- Patient records must be maintained at both the ESRD facility and the ESRD's LTC location
- Must contain a multidisciplinary, written, individualized care plan that is updated as required
- The LTC staff and ESRD facility staff communicates and coordinates the development and implementation of the care plan



LTC Survey

- Home dialysis occurring onsite – Please provide
 - Resident's names
 - Room numbers
 - Name of ESRD assigned caregiver/technician – is this a staff member of the ESRD facility, the DME supplier, or LTC facility?
 - Days and times when each resident will receive dialysis treatment
 - Provide copy of agreement between Nursing Home and ESRD provider



LTC Survey Cont.

- LTC Surveyors will perform:
 - Observations of dialysis treatment areas
 - Observations of storage locations of dialysis equipment
 - Interviews with residents &/or family
 - Interviews with staff members
 - Record/Document reviews



LTC Survey Cont.

- Record/Document Review
 - Evidence of sufficient staffing
 - Evidence that LTC staff and ESRD facility staff coordinate the assessment and care planning
 - Ensure home dialysis is appropriate for patient
 - Ensure patient was educated and given the choice for this modality
 - Care plans are developed, updated and individualized to the patient's needs
 - LTC staff communicates nutritional or psychosocial concerns to ESRD dietician or social worker
 - Resident's response to dialysis treatment
 - Problems identified with dialysis treatment and care are reported to Quality Program



Similarities

- Both the ESRD surveyors and the Long Term Care are looking at the collaboration between the two facilities
- LTC surveyors will communicate concerns identified to the complaint intake unit which could generate a complaint survey by the ESRD surveyors



Resources: Links to S&C memos related to ESRD in LTC

- CMS released two Survey and Certification memorandums pertaining to dialysis in the long term care setting: S&C: 04-24 and S&C: 04-37. Links to the respective memos are provided below
- <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions-Items/CMSo22981.html>
- <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions-Items/CMSo23004.html>



Resources: ESRD CORE survey documents

- <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/ESRD-Core-Survey-Field-Manual.pdf>



***THANK
YOU for
LISTENING***

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APPENDIX – A

7.14 Renal Dialysis Unit (Acute and Chronic)

- A.7.14 The unit should comply with the guidelines of the Association for Advancement of Medical Instrumentation (AAMI) and the requirements of the CMS as found in 42 CFR section 405.2102 and following for End Stage Renal Disease (ESRD).
- 7.14.A General

Acute care dialysis may occur at patient bedside in critical care units and elsewhere. In these cases, dedicated utilities (water and water drain) shall be provided. Section 7.14 shall apply to chronic outpatient (ESRD) facilities or dedicated inpatient units in hospital and nursing facilities.
- 7.14.A1 (Not Used)
- 7.14.A2 (Not Used)
- A.7.14.A2 The location should offer convenient access for outpatients. Accessibility to the unit from parking and public transportation should be a consideration.
- 7.14.A3 (Not Used)
- A.7.14.A3 Space and equipment should be provided as necessary to accommodate the operational narrative, which may include acute (inpatient services) and chronic cases, home treatment and kidney reuse facilities. Inpatient services (acute) may be performed in critical care and designated areas in the hospital, with appropriate utilities.
- 7.14.B Treatment Area
- 7.14.B1 The treatment area shall be separate from administrative and waiting areas.
- 7.14.B2 Nurse's station(s) shall be located within the dialysis treatment area and designed to provide visual observation of all patient stations.
- 7.14.B3 A minimum of 100 square feet of clear floor area shall be provided per bed/stretcher treatment station. A minimum of 80 square feet of clear floor area shall be provided per chair treatment station. A minimum of 4 feet clearance shall be provided between chairs/beds/stretchers, between the side of chair/beds/stretchers and walls, and beyond the foot of the station as an aisle for access to each station. Provide a minimum head wall width of 8 feet for treatment stations. Handwashing facilities shall be provided consistent with Section 2.1.A.
- 7.14.B4 (Not Used)
- 7.14.B5 The unit shall be designed to provide privacy for each patient.
- 7.14.B6 The number of and need for required airborne infection isolation rooms shall be determined by an infection control risk assessment. When required, the airborne infection isolation room(s) shall be consistent with the requirements of Section 7.2.C., except that toilet rooms and bathing facilities are not required.
- 7.14.B7 Service areas shall be provided consistent with the requirements of 2.7 and the operational narrative.



APPENDIX - A

7.14 Renal Dialysis Unit (Acute and Chronic)

- 7.14.B12 If dialyzers are reused, a reprocessing room is required. It shall be sized to perform the functions required. The reprocessing room shall be designed to provide work flow from soiled to clean.
- 7.14.B13 (Not Used)
- 7.14.B14 The housekeeping room shall be for the exclusive use of the unit.
- 7.14.B15 If required by the operational narrative, an equipment repair and breakdown room shall be provided. It shall be equipped with a hand wash sink, work counter and storage cabinet.
- 7.14.B16 (Not Used)
- 7.14.B17 (Not Used)
- 7.14.B18 (Not Used)
- 7.14.B19 Each facility shall provide a separate room for storage of bulk materials, equipment used in preparation and clean-up of jugs used for providing dialysis solutions consistent with the operational narrative. This room can be used for water treatment or other bulk storage functions.
- 7.14.B20 The water treatment equipment shall be located in an enclosed room.
- 7.14.B21 Provide a patient toilet room convenient to the treatment area.
- **7.14.C** Ancillary Facilities
- 7.14.C1 Staff clothing change areas. Appropriate areas shall be provided for male and female personnel (orderlies, technicians, nurses, and doctors) working within the unit. The areas shall contain lockers, water closets, handwashing facilities, and space for changing clothes.
- 7.14.C2 Storage for patients' belongings shall be provided.
- 7.14.C3 A waiting room, toilet room, drinking fountain, access to a public telephone, and seating accommodations shall be available or accessible to the dialysis unit.
- A.7.14.C3 Before the proliferation of cellular telephones, pay phones were more ubiquitous and the minimum design standards required that public telephones be provided in or near renal dialysis units. The wording has been changed to require "access to" a public telephone, which would permit the facility the option to simply allow patients to use a staff telephone in the area. If a pay phone is not provided, the phone designated for patient use should be identified with a sign. If the phone is not located in a public area, the sign should indicate how a patient might obtain access to the phone.
- 7.14.C4 Office and clinical work space shall be available for administrative services.



2016 MDS 3.0 Updates

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Objectives

- Identify major changes in the MDS 3.0.
- Identify the purpose of *Improving Medicare Post-Acute Care Transformation* (IMPACT) Act of 2014 in relation to the 2016 MDS 3.0 update.

IMPACT Act

- Bipartisan bill of IMPACT Act of 2014 passed on September 18, 2014 and signed into law by President on October 6, 2014.
- This Act requires the submission of standardized Patient/resident Assessment Data, Across all *Post-Acute Care* (PAC) settings.
- The data must be submitted on admission and discharge for each resident, or more frequently as required.

Purpose of IMPACT Act

- Purposes of the IMPACT Act are:
 - Improvement of Medicare beneficiary outcomes.
 - Provider access to longitudinal information to facilitate coordinated care.
 - Enable comparable data and quality across PAC settings.
 - Improve hospital discharge planning.
 - Research to enable payment models based on patient **characteristics**.

Reason for IMPACT Act

- Standardized resident/patient assessment data across PAC settings will enable:
 - Quality care and improved outcomes.
 - Data element uniformity.
 - Comparison of quality and data across PAC settings.
 - Improved, person-centered, goal-driven discharge planning.
 - Exchangeability of data.
 - Coordinate care.

SNF Quality Reporting Program (QRP)

- In response to the reporting requirements under the IMPACT Act, CMS established the SNF QRP and its quality reporting requirements in the fiscal year 2016 SNF PPS.
- Per the statute, SNFs that do not submit the required quality measures data may receive a two percentage point reduction to their *Annual Payment Update* (APU) for the applicable payment year.

SNF QRP & payment determination

- Data Collection timelines and requirements for the *Fiscal Year* (FY) 2018 payment determination and subsequent years will be based on one quarter of data from 10/1/2016 to 12/31/2016.
- CMS will collect data on residents who are admitting to the SNF on and after October 1, 2016, and discharged from the SNF up to, and including, December 31, 2016.

SNF QRP & Quality Measure

- CMS has adopted three *Quality measures* (QMs) for the QRP.
- These three QMs will be collected beginning on October 1, 2016 for FY 2018 and subsequent annual payment determinations.
- All three of these quality measures use assessment data from the MDS.

Quality Measures

- The Three QMs adopted in the FY 2016 are:
 - 1) Percentage of residents experiencing one or More Falls with Major Injury.
 - 2) Percentage of residents with pressure ulcers that are New or Worsened.
 - 3) Percentage of the *Long-Term Care Hospital* (LTCH) patients with an Admission and Discharge Functional Assessment and a care plan that addresses Function.

Main changes on RAI/MDS 3.0 as of October 2016

- Item set wording changes.
- Addition of the Part A PPS Discharge assessment.
- Addition of section GG (Functional Abilities and Goals).
- Delirium assessment update.
- Modifying injuries related to falls.
- Determining whether *Pressure ulcer* (PU) is considered “Present on Admission” or not.
- Simplified posting of the RAI manual and MDS forms.

MDS submission

- The October 1, 2016 implementation of the SNF QRP will **Not** change the process of MDS 3.0 data submission through QIES ASAP system.
- However there are two major changes to the MDS 3.0 effective October 1, 2016:
 - Additional MDS submission- the **Part A PPS Discharge Assessment**.
 - Addition of **Section GG**.

Discharge Assessments

- A0310F:
 - 1) OBRA discharge Return anticipated
 - 2) OBRA Discharge Return Not Anticipated

- A0310H:
 - 3) **Part A PPS Discharge assessment.**

Part A Discharge Assessment

- The Part A PPS Discharge assessment is developed to inform current and future:
 - SNF QRP measures, and
 - Calculation of these measures.
- The Part A PPS Discharge assessment consistent of:
 - Demographic items.
 - Administrative items.
 - Clinical items.

Part A Discharge Assessment

(continued)

- The Part A PPS discharge assessment is completed when:
 - A resident's Medicare Part A stay ends, **But**
 - The resident remains in the facility.
 - The End Date of the Most Recent Medicare Stay (A2400C) earlier than the actual Discharge Date (A2000) from the facility.

Part A Discharge Assessment

(continued)

- If a resident is physically discharged on the same day or within one day of the end of the Medicare Part A stay the following discharge assessments must be completed:
 - 1) OBRA Discharge assessment, and
 - 2) Part A PPS discharge assessment.

Part A Discharge Assessment

(continued)

- The Part A PPS discharge assessment is **not** completed when:
 - The discharge is unplanned.
 - If the End Date of Most Recent Medicare Stay (A2400C) **occurs on the same day** that the resident dies.

Delirium assessment (C1310)

CAM Assessment Scoring Methodology

The indication of delirium by the CAM requires the presence of:

Item A = 1 **OR** Item B, C or D = 2

AND

Item B = 1 or 2

And either

Item C = 1 or 2 **OR** Item D = 1 or 2

Quality reporting related to fall with major injury

- QM related to the Percentage of residents experiencing one or More Falls with injury is intended for the cross-setting measure to meet the requirements on the IMPACT Act of 2014 across PAC settings.
- This QM reports the percentage of Medicare Part A residents who are:
 - Experiencing one or more falls with major injury that occurred during the SNF stay.

Fall(s) with Major Injury (J1900)

- Gathering accurate information beyond the ARD related to the fall that occurred during the look back period.
- Modification of the MDS assessment for resident who was experiencing one or more falls with major injury.

Quality reporting related to the Skin Integrity

- QM related to Percentage of residents/patients with pressure ulcers that are new or worsened.
- This QM is adapted as a cross-setting measure to meet the requirements of the IMPACT Act of 2014.
- This QM addressing the domain of skin integrity and changes in skin integrity.

QRP related to the Skin Integrity *(continued)*

- This measure is intended to encourage PAC providers:
 - To prevent pressure ulcer development or worsening,
 - To closely monitor the resident's pressure ulcers, and
 - Appropriately treat existing pressure ulcers.

Skin Assessment

- For each pressure ulcer determine:
 - The deepest anatomical stage.
 - The current and historical levels of tissue involvement.
 - Current number of unhealed pressure ulcer at each stage.
 - Identify unstageable pressure ulcers.
 - Determine “Present on Admission.”
- ★ **Do Not reverse or back stage.**

Determining present on admission

- Pressure ulcer “Present on admission” means it was NOT acquired in the facility.

Quality measure related to Functional Abilities and Goals

- QM related to Application of present of Long-Term Care Hospital patients with an Admission and Discharge Functional Assessment and a care plan that address Function.

Functional Abilities and Goals

- CMS adapted this measure to satisfy the IMPACT Act requirements.
- This QM requires PAC providers report standardized data regarding:
 - Functional status,
 - Cognitive function, and
 - Changes in function and cognitive function.

Functional Abilities and Goals

(continued)

- This QM reports:
 - The percent of resident with an admission and discharge functional assessment, and
 - At least one goal that addresses function.
- Items in section GG are used to calculate this quality measure for PAC settings.

Section GG: Functional Abilities and Goals

- Items in section GG focus on resident's self-care and mobility:
 - Admission **performance**,
 - Discharge **goals**, and
 - Discharge **performance**.
- Section GG assess the need for assistance with, and establish goals for:
 - Self-care (GG0130).
 - Mobility activities (GG0170).

Section GG (continued)

- Code the resident's:
 - **Usual performance** at the Start of the SNF PPS stay (Admission) for each activity.
 - End of the SNF PPS stay (Discharge) **goals**.
- Complete only if:
 - A0310B=1 (PPS 5-day assessment),
 - A0310G=1 (Planned discharge),
 - A0310H=1 (Part A PPS Discharge).



Questions

Glossary - MDS 3.0 coding items used in this presentation

- A310: Type of Assessment
- A310B: PPS assessment
- A310B1: 5-day scheduled PPS assessment
- A310F10: OBRA discharge return not anticipated
- A310F11: OBRA discharge return anticipated
- A310G: Type of Discharge
- A310G1: Planned Discharge
- A310G2: Unplanned discharge
- A310H1: Part APPS discharge assessment
- A2000: Discharge Date
- A2400: Medicare Stay
- A2400B: Start date of most recent Medicare stay
- A2400C: End date of most recent Medicare stay

Glossary (continued)

- C1310: Signs and Symptoms of Delirium (from CAM ©)
- C1310A: Acute onset mental status change (0=No, 1=yes)
- C1310B: Inattention
- C1310C: Disorganized thinking
- C1310D: Altered level of consciousness
- Coding scale for C1310:
 - 0: Behavior not present
 - 1: Behavior continuously present, not fluctuate
 - 2: Behavior present, fluctuate
- GG0130: Self -Care
- GG0170: Mobility
- J1900: Number of falls since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS), whichever is more recent

Acronym used in this presentation

- APU: Annual Payment Update
- ARD: Assessment Reference Date
- CAM: Confusion Assessment Method
- FY: Fiscal Year
- IMPACT Act: Improving Medicare Post-Acute Care Transformation Act
- LTCH : Long-Term Care Hospital
- MDS: Minimum Data Set
- OASIS: Outcome and Assessment Information Set
- OBRA: Omnibus Budget Reconciliation Act

Acronym used in this presentation

(continued)

- PAC: Post-Acute Care
- PPS: Prospective Payment System
- PU: Pressure Ulcer
- QIES ASAP : Quality Improvement and Evaluation System Assessment Submission and Processing
- QM: Quality Measure
- QRP: Quality Reporting Program
- RAI: Resident Assessment Instrument
- SNF: Skilled Nursing facility

Michigan Nurse Aide Registry

Tom Novak

Manager Enforcement and Compliance

Objectives

- Understand where responsibility and authority for Michigan CNA program resides
- Requirements for CNA certification and recertification in Michigan
- Understand where to find CNA certification resources



Certified Nurse Aide (CNA) Registry

- Previously located in the Bureau of Professional Licensing until February 2016
- Currently located in the Bureau of Community and Health Systems
- Health Facility Professional and Nurse Aide Section is the new section. This section is responsible for:
 - Investigations of allegations
 - Will investigate CNA allegations of abuse, neglect and misappropriation
 - Appeal option for administrative hearing
 - Maintaining Nurse Aide Registry and Nurse Aide Training Programs



Certified Nurse Aide (CNA) Registry cont.

- Michigan contracts with Prometrics to
 - Conduct testing and determine competency to work as a CNA
 - Coordinate the management and posting of the CNA registry in Michigan
 - Work with BCHS to flag personnel on the registry found to abuse, neglect or misappropriate property of vulnerable adults in nursing facilities



Requirements for CNA Certification

- Be at least 18 years of age
- Completed a Michigan-approved training course within the last 24 months
- Completed and passed both the written and practical examinations provided by Prometrics

CNA Recertification Requirements

- Worked at least eight hours for pay in a long-term care facility verified by signature
- Completion of recertification documentation
- Submission to Prometrics so that renewal documents are received (M-F, 8-5) before the certification expires
- Not been found guilty of abuse, neglect or misappropriation of property in long-term care

Michigan CNA Registry Website and other Resources

- www.Michigan.gov/bchs
 - Click on the Nurse Aide Registry Button
- Email: bchs-cna-registry@michigan.gov
- Federal Regulations:
http://www.michigan.gov/documents/mdch/mdch_na_federal_rules_regulations_287782_7.pdf

Michigan CNA Registry FAQs

- Exemptions from training
- Originally certified in MI but it lapsed
- Reciprocity
- Grace periods
- Hardship
- Documents were mailed by the expiration date
- Facility won't sign my renewal
- Renewal date is less than two years

PROMETRIC



Michigan Certified Nursing Assistant Program

September 20, 2016



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1 5432142323
1 9800099

Agenda

- **Introductions**
- **Prometric Overview**
- **Nurse Aide Exam Overview**
- **MICNA 2015 Year in Review**

Michigan Nurse Aide Certification Exam Program Overview

- **Client:** The Michigan Department of Licensing and Regulatory Affairs (LARA)
- **Prometric Services**
 - Application processing
 - Customer service (call center, email box)
 - Eligibility determination
 - Exam registration and scheduling
 - IBT exam administration
 - Score reporting and results management
 - Registry

Prometric.Com/Nurseaide Resource Center



NURSE AIDE

WE NEED YOUR HELP!

CERTIFIED NURSES ASSISTANT

Click for More Info

Test Takers

Trainers & Test Centers

Employers

Prospective Clients

Alabama | Arkansas | Connecticut | Delaware | Florida | Hawaii | Idaho | [Michigan](#) | New Mexico | New York | Oklahoma

Michigan Nurse Aide Exam

Take a Practice Exam



Are you nervous about your exam? Shake the nerves by taking a practice exam.

Go

Select Your Testing State



Prometric offers Nurse Aide testing in many states. Check for your state.

Go

Registry Services



Check the registry status for your employees.

Go



Practice Exam



Select Testing State



Join the Mailing List



FAQs

Candidate Information Bulletin



Online Application



Track the Status of My Application



Take a Practice Exam



Check Registry Status



Important Changes Beginning March 2015

- [Updates to the Michigan State Certified Nurse Aide Exam](#)

General Information Documents

- [Candidate Information Bulletin](#)
- [Application Form](#)
- [Candidate Survey](#)
- [Change Request Form](#)
- [Test Center List](#)

- [Clinical Skills Checklist](#)
- [Clinical Skills Instructions](#)
- [Indirect Care Behaviors](#)
- [Measurement Forms](#)
- [ADA Request Packet](#)

Registry Services

- [Michigan Nurse Aide Registry](#)
- [MI NA Registry Renewal Form](#)
- [Sample Renewal Letter](#)

Contact

Questions that were not answered in the documents and information above can be emailed to MICNA@prometric.com. In order for your question to be answered in an accurate and timely manner, your email should include your name, address, date of birth and ID# (if known)

Prometric
MI Nurse Aide
7941 Corporate Dr.
Nottingham MD 21236
Phone: 800.752.4724



Practice Exam



Select Testing State



Join the Mailing List



FAQs



Contact Us

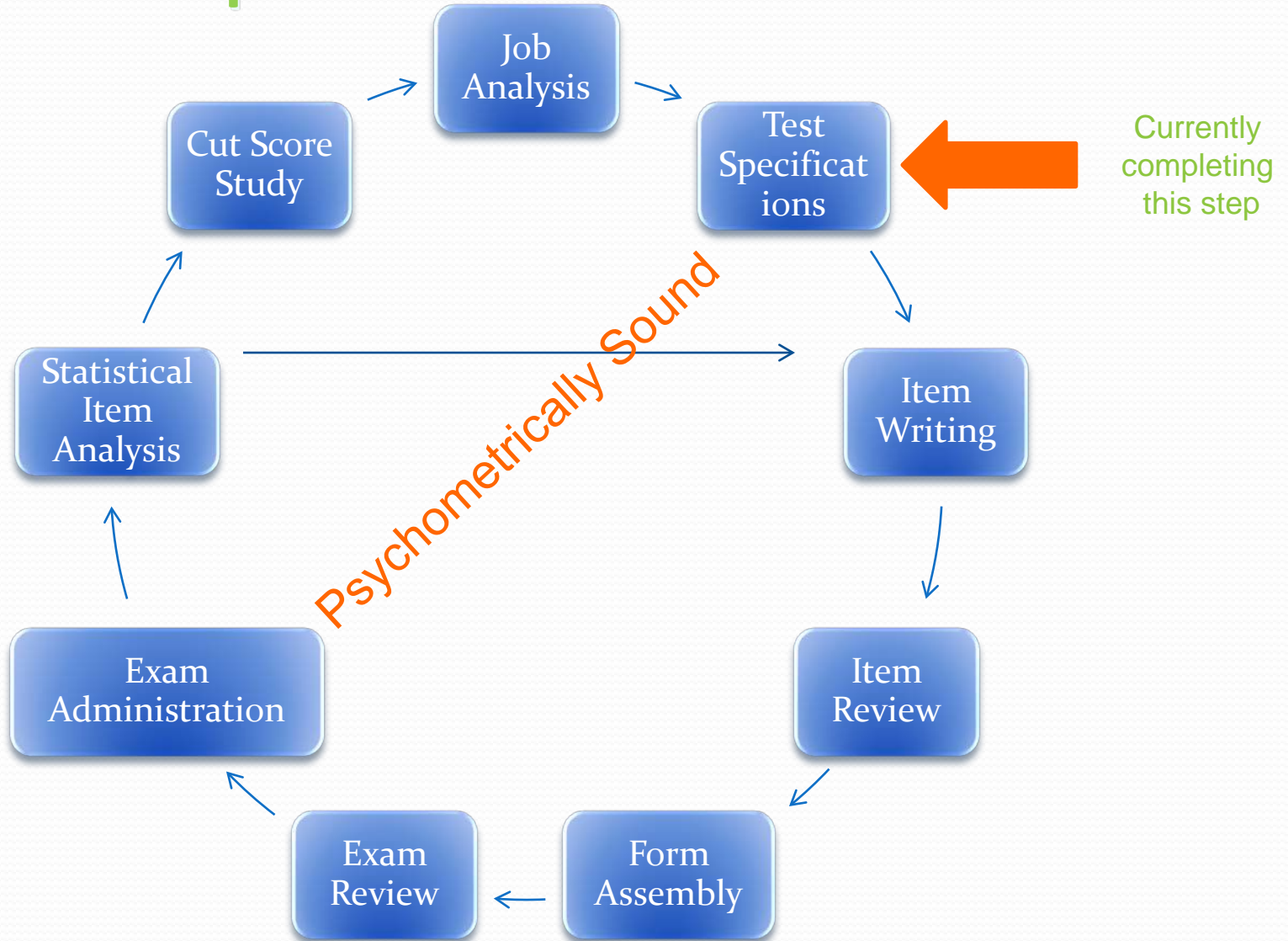
Job Task Analysis

- Initiating a new nurse aide exam development cycle
- Internal kick-off/planning meetings held in May/June
- Task Force with multi-state SME representation assembled to review/develop a Job Analysis Survey Tool
 - 3 Michigan representatives on the Task Force
- Job Analysis Survey deployed in late June
 - Solicits feedback from the industry on the knowledge, skills, and abilities required to be a nurse aide
 - 571 completed responses to date
 - 89 Michigan responses
 - Survey data is being analyzed
- Next Steps:
 - Recruit SMEs for upcoming Task Force meetings
 - Complete remaining steps in the exam update cycle

Test Creation Concepts

REQUIREMENT	DEFINITION
VALIDITY	<p>The extent to which inferences and actions made on the basis of a set of scores are appropriate and justified by evidence. Does the test:</p> <ul style="list-style-type: none">• measure what it says it measures?• identify minimally qualified individuals?
RELIABILITY	<p>An indicator of the extent to which scores will be consistent across different administrations.</p>
FAIRNESS	<p>The extent to which a product or service is appropriate for members of different groups, and the extent to which users of products or services are treated the same way, regardless of gender, race, ethnicity, and the like.</p>
STANDARDIZED TESTING	<p>A test designed in such a way that the questions, conditions for administering, scoring procedures, and interpretations are consistent and are administered and scored in a predetermined, standard manner.</p>

Test Development Process



Nurse Aide Competency Examination

Purpose of the examination is **public protection** to ensure that individuals added to Michigan nurse aide registry, who will provide care to nursing home residents, have **met standards of minimal competency**.






Written Test Specifications

TEST SPECIFICATIONS

Content Areas	Percentage Weight	Number of Test Items
1. Role of the Nurse Aide	18	9
2. Promotion of Safety	18	9
3. Promotion of Function and Health of Residents	24	12
4. Basic Nursing Care Provided by the Nurse Aide	26	13
5. Providing Specialized Care for Residents with Changes in Health	14	7
Total	100.00%	50

Updated Clinical Skills Matrix

Level of Difficulty	Personal Care 	Promotion of Health and Function 	Measurement and Record 
Most	Perineal care Catheter care Dressing Change occupied bed	Positioning Transfer	Pulse
Moderate	Bedpan Partial bed bath Mouth care-brushing teeth Mouth care-denture care	Ambulate Range of Motion: hip, knee and ankle	Contents urinary drainage bag Feeding
Least	Hand and nail care Foot care	Range of Motion: shoulder Range of Motion: elbow and wrist	Respirations

Sample Skills Checklist

Dress a resident who has a weak arm	
The candidate is asked to put a long-sleeved button-front shirt, pants, and socks on a resident who is lying in bed. The resident is not able to help with the dressing and has a weak arm. A mannequin is used for the role of the resident.	
Does the candidate:	
1	Greet resident, address by name, and introduce self? (IC)
2	Provide explanations to resident about care before beginning and during care? (IC)
3	Include resident in decision-making about clothing to wear?
4	Collect all garments before removing hospital gown?
5	Support affected arm while undressing and dressing?
6	Remove hospital gown?
7	Dress affected arm first?
8	Gather up sleeve to ease pulling over affected arm?
9	Dress resident by putting on pants, shirt with sleeves, and socks?
10	Move resident's extremities gently without over-extension or force when undressing and dressing?
11	Apply clothing correctly (e.g. front of shirt in front), adjust clothing for comfort, neatness, alignment, and close fasteners?
12	Place dirty gown in hamper?
13	Keep resident positioned a safe distance from the edge of the bed at all times?
14	Ask resident about preferences during care? (IC)
15	Use Standard Precautions and infection control measures when providing care? (IC)
16	Ask resident about comfort or needs during care or before care completed? (IC)
17	Promote resident's rights during care? (IC)
18	Promote resident's safety during care? (IC)

Clinical Skills Instruction Card

CLINICAL SKILLS TEST INSTRUCTION CARD

The care plan requires that the residents receive the care listed below. Perform the care in the order listed.

Resident 1

Range of Motion ~ Upper Extremity

Provide range of motion (ROM) exercises to the resident's left shoulder, elbow, wrist and fingers. Provide three repetitions of each exercise. The resident is not able to help with the exercises.

Resident 2

Catheter Care

The resident has an indwelling urinary catheter. Use soap and water to provide catheter care to the resident. The drainage bag does not need to be emptied.

Resident 3

Measure and Record Contents of Urinary Drainage Bag

Measure and record the contents of the urinary drainage bag. Record your results in cc's on the Intake and Output (I&O) Form.

TCNet View

Prometric TC Net - Prometric X

Matthew

https://tcnet1.prometric.com/Candidate/CandidateTest.aspx

TC Net Domain : ARCNA /ARCNA msnyder PROMETRIC

CANDIDATE PROCTOR AUTHORIZING AUTHOR REPORTS ADMIN ADMIN REPORTS

Take Test Select and take a test. [Take](#)

Resume Test Resume a test that you already started. This option is useful if you closed your browser or restarted your computer while taking a test.
NOTE: Once you click the "begin test" button, your test time CONTINUES to count down even if you have closed your browser or restarted your computer. [Resume](#)

Take Practice Test Select and take a practice test. [Practice](#)

Review Scores View a complete history of every test you have taken, including results and payment receipts. [History](#)

Feedback Have a suggestion for the improvement of this system? Our ears are wide open for your feedback. [Feedback](#)

FAQ About Prometric Contact Us

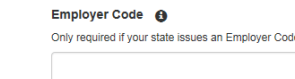
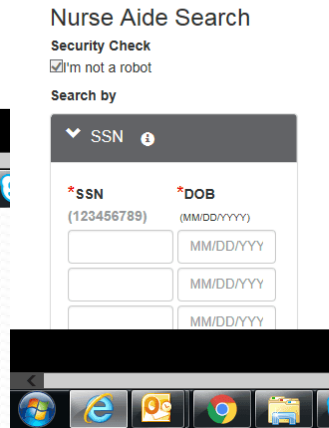
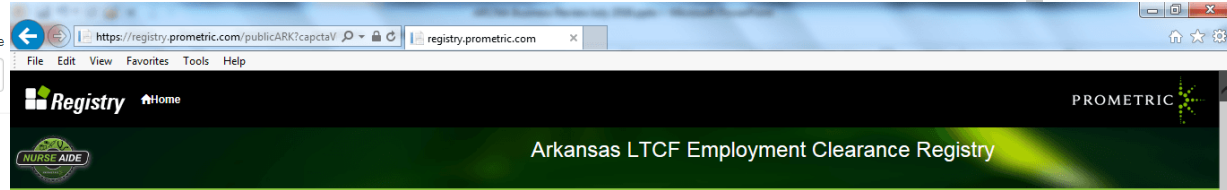
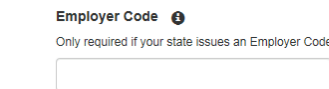
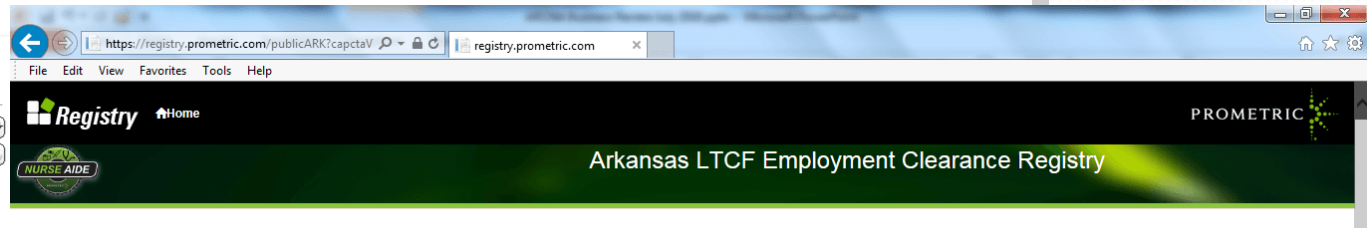
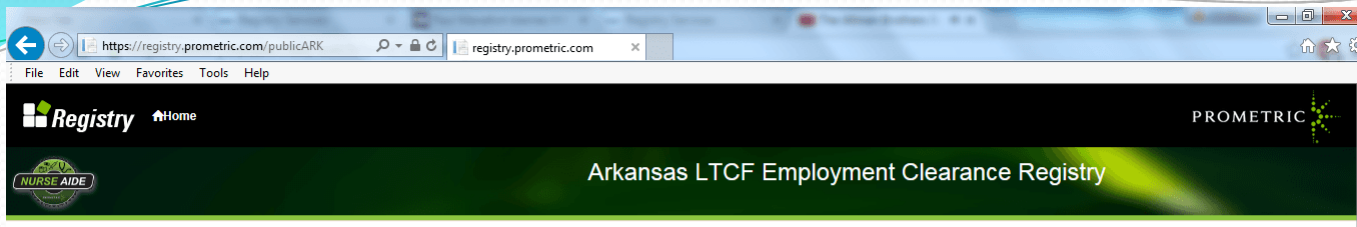
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Prometric Technology Updates

Registry Redesign

- In the storyboard phase of a registry redesign.
- More functionality and security
- Easier end-user functions
- Eliminating old/not used functionality
- Better reporting capabilities

New Public Registry View – Went Live July 6



Nurse Aide Search

Security Check

☒ I'm not a robot

Search by

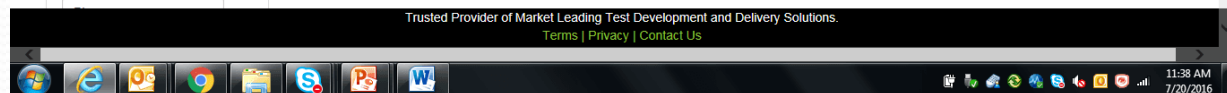
Search by options:

- SSN
- Certificate #
- Name

*First Name

Total Records : 2

Name	First Name	Last Name	Middle Name	Abuse Findings or Convictions	Original Cert Date	Expiration Date
Bianca Brown	BIANCA	BROWN	L	No	07/02/2014	07/02/2016
Bianca Brown	BIANCA	BROWN		Yes	Not Certified	



Program Overview Jan 2016 – Aug 2016

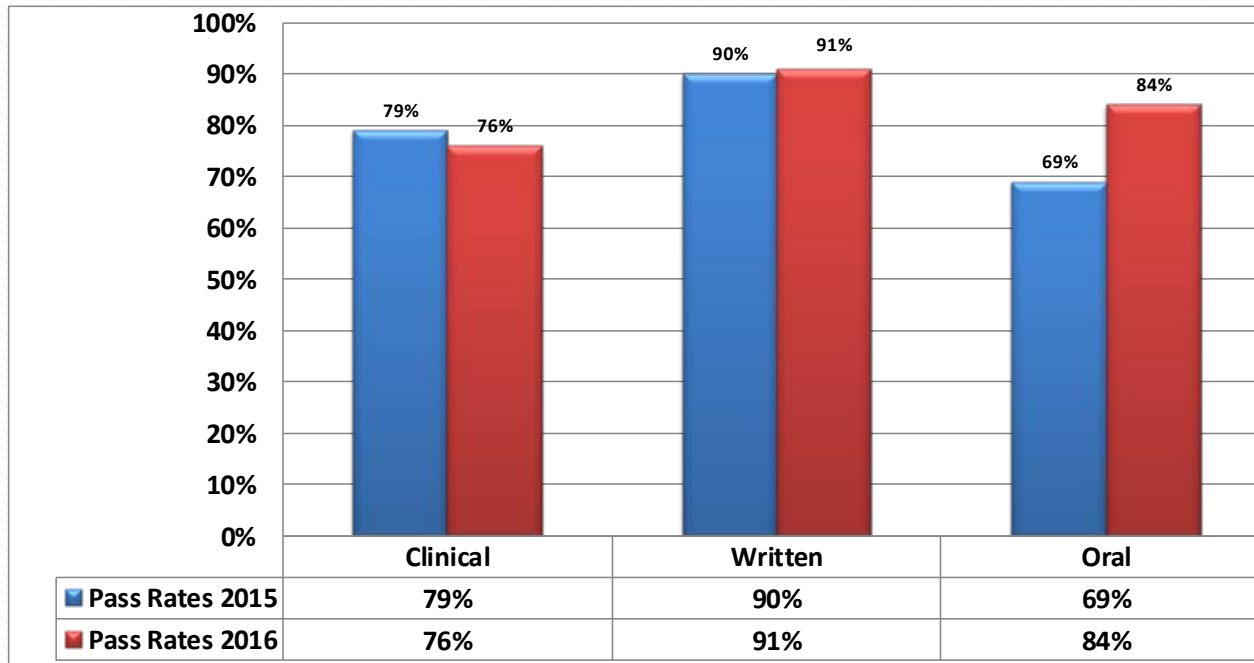
- 14,929 tests administered
- 1,479 no shows (exams)
 - 9% no shows
- 11,504 calls handled by call center staff
- 13,936 renewals processed

State	Exams	No Shows	%
MI	16,408	1,479	9%
State A	31,800	2,940	9%
State B	24,690	2,445	10%
State C	8,912	1,557	17%

Jan 2016 – Jul 2016 Statistics

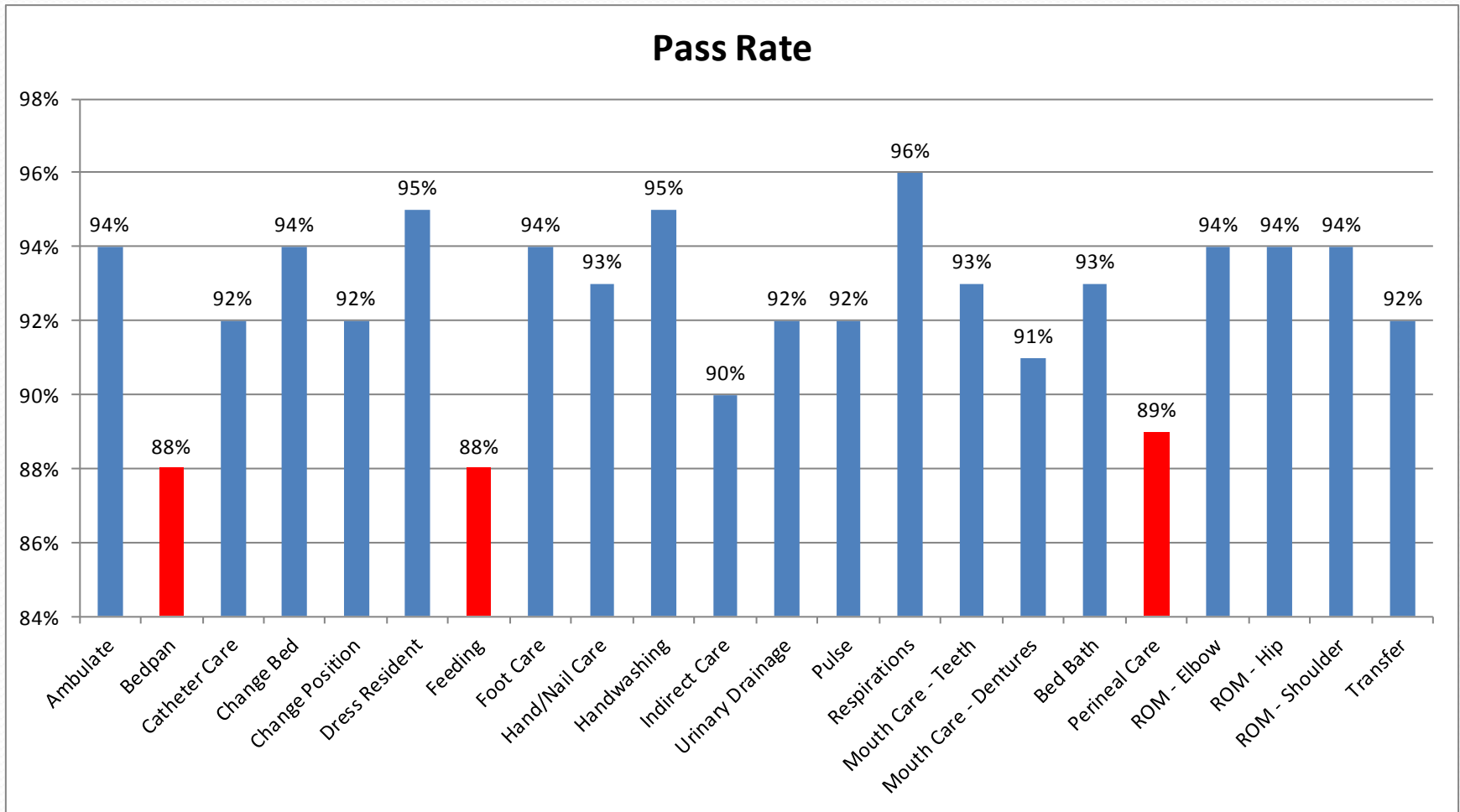
Month	Calls	Applications	Renewals
Jan	507	299	1358
Feb	480	480	1936
Mar	597	793	2022
Apr	551	603	1781
May	604	987	1748
Jun	640	793	1777
Jul	554	584	1570
Totals	10904	4539	12192

Pass Rates for Year Over Year Comparison



State	Clinical	Written	Oral
State A	72%	81%	67%
State B	81%	80%	70%
State C	64%	83%	55%

Pass Rate By Skill – Jan 2015 – Feb 2016





Plan of Correction It's A QAPI Process

JPST

September 2016

Speakers

- John Rojeski
Manager, LARA. Long Term Care
rojeskij@michigan.gov
- Vickie Burlew, RN, LNA.
Consultant. Lebenbom & Rothman, P.C
vburlew@lrhealthlaw.com

Federal Requirements for Acceptable Plan of Correction

- 5 Criteria established by CMS
- If any component missing, the plan of correction will not be approved and remedies will be imposed immediately
- Facility cannot delay PoC due to deficiency being contested

Acceptable Plan of Correction

- The Statement of Deficiency is a public record; therefore, the appropriate facility response to each allegation is critical

Acceptable Plan of Correction

- The Plan of Correction: only **public** place that you address survey findings
 - Accessed by families, newspapers, financial institutions, and attorneys
 - Must be posted in a public place for residents/families to view
 - Cannot dispute findings in POC

Disclaimers

- Disclaimers are statements which deny the allegations along with the seriousness of the concern.
- Disclaimers establish the fact that the Plan of Correction is being submitted due to requirement of law, not because facility agrees with the citation
- On the first page of the POC only before any answers to deficiencies.

State Recommended Disclaimers

- **"(Facility Name) does not necessarily agree with all statements and conclusions in the CMS-2567 and submits this Plan of Correction in response to the *Statement of Deficiencies* received as requested by the State Survey Agency."**

LARA

April 4, 2013

GUIDELINES FOR THE DEVELOPMENT OF A PLAN OF CORRECTION (POC) FOR LONG TERM CARE FACILITIES

RESIDENT-SPECIFIC CITATION

Resident Specific

- Element 1: General accounting of how the deficiencies cited for a specific resident have been corrected.
- Element 2 must state how all other residents who have been, or could be, affected by the generic deficient practice have been identified.
- Elements 3 and 4 must demonstrate that the facility has considered all residents in their plan development.

Element One

- HOW the corrective action will be accomplished for ***those residents*** found to have been affected by the deficient practice
 - Element #1: For the residents identified in this document (or 2567), we did the following:
 - Must list each resident separately even if the 2567 groups them together.

Element One

- Review each resident cited in exit and develop an individualized plan to correct the practice. Involve those providing care to the resident
- Include
 - Interview and involvement of resident and resident's choices
 - Assessment by IDT
 - Evaluation by MD or RPh if needed,
 - Review and **update** to care plan.

Element One

- Each statement should say which member of the IDT completed the action. E.g. The Clinical Care Coordinator completed a Falls Risk Assessment on Resident #2016 (may want to include the date). The IDT and resident met and reviewed the assessment, the resident's fall history and root causes. They then reviewed the resident's care plan and updated the care plan (or deemed it appropriate).

Element One

- Don't stop with this. List all of the actions.
 - Pharmacy
 - How was the resident involved? For some plans of correction, the resident's INFORMED choice and education may be crucial to the POC.

Element Two

- **HOW** the facility will **IDENTIFY** other residents having the potential to be affected by the same deficient practice
 - Element #2: To identify other residents who had similar circumstances, we did the following:

Element Two

- Review the sample: are there others that may appear on the 2567.
- Audit or review of the other residents with similar circumstances.

Develop a Strategy for Collecting and Using Data

- Areas to consider for Element #2
 - Quality Measure Reports identify those who trigger for the same QM
 - MDS Audit of applicable sections
 - Pharmacy reports
 - Chart audit
 - Risk Assessments
 - Similar diagnoses
 - Incident Reports
 - Infection Control Logs

Develop a Strategy for Collecting and Using Data

- Areas to consider for Element #2
 - Resident / Family Council Meetings
 - Individual Interviews with residents and families
 - Minutes of past resident / family council minutes
 - Ombudsman
 - Facility Customer Service records
 - Staff Interviews
 - Observations of care delivery
 - Round of the physical plant

Develop a Strategy for Collecting and Using Data

- Areas to consider for Element #2
 - Preventative Maintenance Logs
 - Food Safety Logs
 - Activity Calendars
 - Menus
 - Resident / Family Satisfaction Surveys

Element Two

- State how you identified other residents clearly. Do not list individually.
- Plan of Correction Instructions do not state that you need to say what you did **BUT it is an expectation.**
- Determine what needs to be done for these residents. (Hint: It may be very similar to what you did in Element 1.)

Caution

- The audits in Element #2 may be the same audits you do in Element #4.
- Make a clear distinction of the time frame of the audits in Element #2 if using same audit tool.
- For example, if auditing MAR for missing initials (potential omitted doses), do it for the month of the survey for Element #2, and then resume under Element #4 on a later date.

Element Three

- **WHAT** measures will be put into place or systemic changes made to ensure that the deficient practice will not recur
 - Element #3: To improve our systems and process related to _____, we did the following:
 - In the previous Elements, you “corrected” for individuals.
 - In this element, you are improving the systems of care

Identify Gaps and Opportunities

- Using Element 2 data plus more, look for patterns and trends:
 - MDS data for problem **patterns**.
 - **Trends** in complaints.
 - Resident and family satisfaction for **trends**.
 - **Patterns** of caregiver turnover or absences.
 - **Patterns** of ER and/or hospital use.

Getting to the “Root” of the Problem

- Root Cause Analysis (RCA) is a term used to describe a systematic process for identifying contributing causal factors that underlie variations in performance. This structured method of analysis is designed to get to the underlying cause of a problem –which then leads to identification of effective interventions that can be implemented in order to make improvements.

Root Cause Analysis

1. Identify What Happened



2. Review what should have happened



3. Determine causes



4. Generate recommendatio

Root Cause Analysis

1. Identify What Happened – the 2567 did that as well as your development of Elements #1 and #2

Root Cause Analysis

2. Review what should have happened – often missed step. Review the policies related to the statement of deficient practice. Create Process Maps.

Root Cause Analysis

3. Determine causes – what are the gaps in the process? Where are the opportunities to improve?

Root Cause Analysis

4. Generate recommendations
– this is your corrective action

Element Three

- **WHAT** measures will be put into place or systemic changes made to ensure that the deficient practice will not recur
 - This must demonstrate that the facility has considered all residents in their plan development.
 - Review and **update** policies and procedures based on root cause analysis and gap identification

Policy Review and Updating

- State who did or will do the review
- Permissible to deem the policy appropriate
- Include list of the updates (more likely to get a desk review if you are clear)
- Be sure you date the policy itself with either review date or “Updated on”
- Best practice but not required: Reference the regulations and attached evidenced-based outcomes resources (AMDA, journal articles, CDC guidelines, etc)

Element Three

- **WHAT** systemic changes are done
 - In-servicing of staff:
 - Outside training – watch dates!
 - Identify who is going to conduct and projected dates
 - Identify the target audience – who performs the care/tasks, who needs to know
 - State how you will train those who are excused
 - Describe oversight by DON or other management personnel

In-Servicing

- Include all changes to any and all policies
- Review basic expectations of policies and standards of practice related to the topic
- Agenda and Proof of attendance is required
- Best practice but not required:
 - Handouts
 - Pre and/or Post Tests
 - Summary of attendance (method to determine target audience did attend)
 - Evaluations

Element Three

- **WHAT** systemic changes are done
 - Use of consultants, resident council feedback ombudsman input, multi-disciplinary QI teams
 - Schedule and complete within 30 days of exit
 - Clearly identify when role changes from change to monitoring
 - Customer surveys
 - Interviews with residents and families

Element Three

- **WHAT** systemic changes are done
 - Physical environment enhancements
 - Staff expansion
 - Staffing adjustments and changes

Element Three

- **WHAT** systemic changes are done
 - Employee action
 - Conduct quality improvement review of the situation identified in this document
 - Identify areas for improvement
 - Train the employee on expectations
 - Establish a work performance improvement plan

Element Three

- Each action must state who completed or will complete the task – dates are great if completed before submission
- Each change must state who is responsible for carrying out the action on a daily basis

QAPI Systemic Action

- Weak: Depend on staff to remember their training or what is written in the policy. (Enhance or enforce existing processes.)
- Examples of weak actions:
 - Double checks
 - Warnings/labels
 - New policies/procedures/memoranda
 - Training/education
 - Additional study

QAPI Systemic Action

- Intermediate: Provide tools to help staff to remember or to promote clear communication. (Modify existing processes.)
- Examples of intermediate actions:
 - Decrease workload
 - Software enhancements/modifications
 - Eliminate/reduce distraction
 - Checklists/cognitive aids/triggers/prompts

QAPI Systemic Action

- More examples of intermediate actions:
 - Eliminate look alike and sound alike
 - Read back
 - Enhanced documentation/communication
 - Build in redundancy

QAPI Systemic Action

- Strong: Do not depend on staff to remember to do the right thing. Provides strong controls. (Change or re-design the process.)
 - Detect and warn so there is an opportunity to correct before the error reaches the patient.
 - Involve hard stops which won't allow the process to continue unless something is corrected or gives the chance to intervene to prevent significant harm.

QAPI Systemic Action

- Examples of strong actions:
 - Physical changes: grab bars, non slip strips on tubs/showers.
 - Forcing functions or constraints: design of gas lines so that only oxygen can be connected to oxygen lines; electronic medical records – cannot continue charting unless all fields filled in.
 - Simplifying: unit dose.

Element Four

- HOW the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur
 - This must demonstrate that the facility has considered all residents in their plan development.
 - **Quality Assurance monitoring** the continued effectiveness of the systemic changes

Element Four

- HOW the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur
 - Who is doing the monitoring?
 - Sample size
 - What
 - Frequency
 - Expected Outcome
 - Action Taken When Improvement Needed
 - Who the monitor reports to
 - Who reports how often to QA

Element Four

- For example
 - Who is doing the monitoring? The Clinical Care Coordinators will observe
 - Sample size: 25% of the residents
 - What: using pressure reduction wheelchair cushions
 - Frequency: twice weekly at random times on different shifts
 - Expected outcome: to determine if cushions are present

Element Four

- For example
 - Expected outcome: to determine if cushions are present
 - Action Taken When Improvement Needed: They will take corrective action when needed
 - Who the monitor reports to: They will report monthly to the DON.
 - Who reports how often to QA: The DON will report patterns and trends to the QA Committee monthly for further recommendations.

Remember

- This is a QA process.
- QA Committee has authority to increase/decrease sample size and frequency.
- POC is not a commitment to do the exact same monitoring until next annual survey.

Element Four

- HOW the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur
 - Return demonstrations
 - Documentation audits
 - Observation of care
 - Staff interviews
 - Environmental Rounds

Element Four

- HOW the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur
 - Quality indicators
 - Surveillance
 - Customer surveys,
 - Resident council feedback, interviews with families/residents

Element Four

- *Must end with a statement of:* Who, within your organization, will be responsible for assuring that substantial compliance is **attained** through the PoC and within the allowable time frames **and** who will be responsible for sustained compliance thereafter
- Usually NHA or DON – occasionally another department head

Criteria Five

- Completion date
 - Realistic
 - ASAP but , , ,
 - 40th day after exit of the survey that opened the cycle



FACILITY-CENTERED CITATIONS

Facility-Centered

- Element #1: How corrective action has been or will be accomplished for the facility centered deficient practice;
- Element #2: What measures have been or will be put into place or systemic changes made to ensure that the deficient practice will not recur; and
- Element #3: How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur; i.e., what quality assurance program will be put into place.
- Element #4: Completion Date

Organize by elements

Identify each element in the POC – don't expect the manager to hunt for them

REMINDERS

Golden Rules for Content

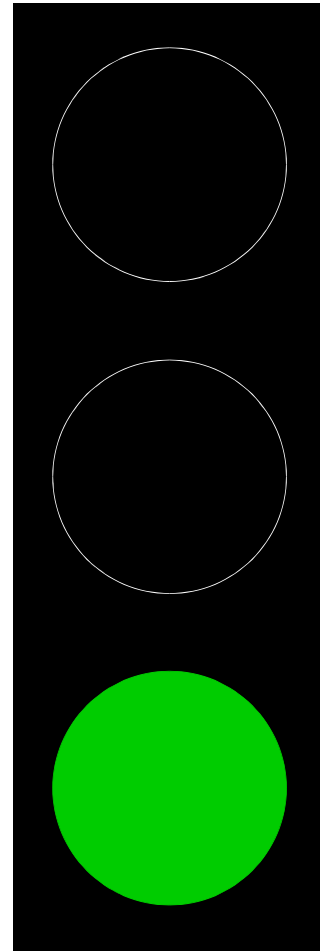
1. Do **not** include resident or facility staff names, allude to another facility or supplier, or malign an individual.
2. Do **not** use all-inclusive wording such as “all”, “everyone”, “at all times”, “always”
3. Do Not offer more than “what’s in the bank”
4. Every action statement state who by position did or will do it

Resident Specific versus Facility Specific

- If the citation is resident specific such as failure to prevent pressure ulcers, dignity of residents, assessment of residents then the POC must have all four components
- If the citation is facility centered such as water temperature, general infection control standards, staffing, then the POC need only to have three components
- However, some citations may deal with both resident and facility systems. For example, F248 - Activities. For deficiencies that have both facets, be sure to address each facet in the corrective response.

Do **NOT** wait
until 2567 arrives

- Have to submit POC even if disputing
- Time is short
- Memories fade



Involve the caregivers and staff who perform the work in the citation

- Let everyone know what the findings are
- Have an open discussion about quality concerns and that it is safe to do so, and that everyone is encouraged to think about systems.
- Establish their understanding of what should have happened – what are your current systems, policies, and procedures?

Involve Your Support Team

- Be sure consultants and contractors are also aware of citations that cross into their expertise.

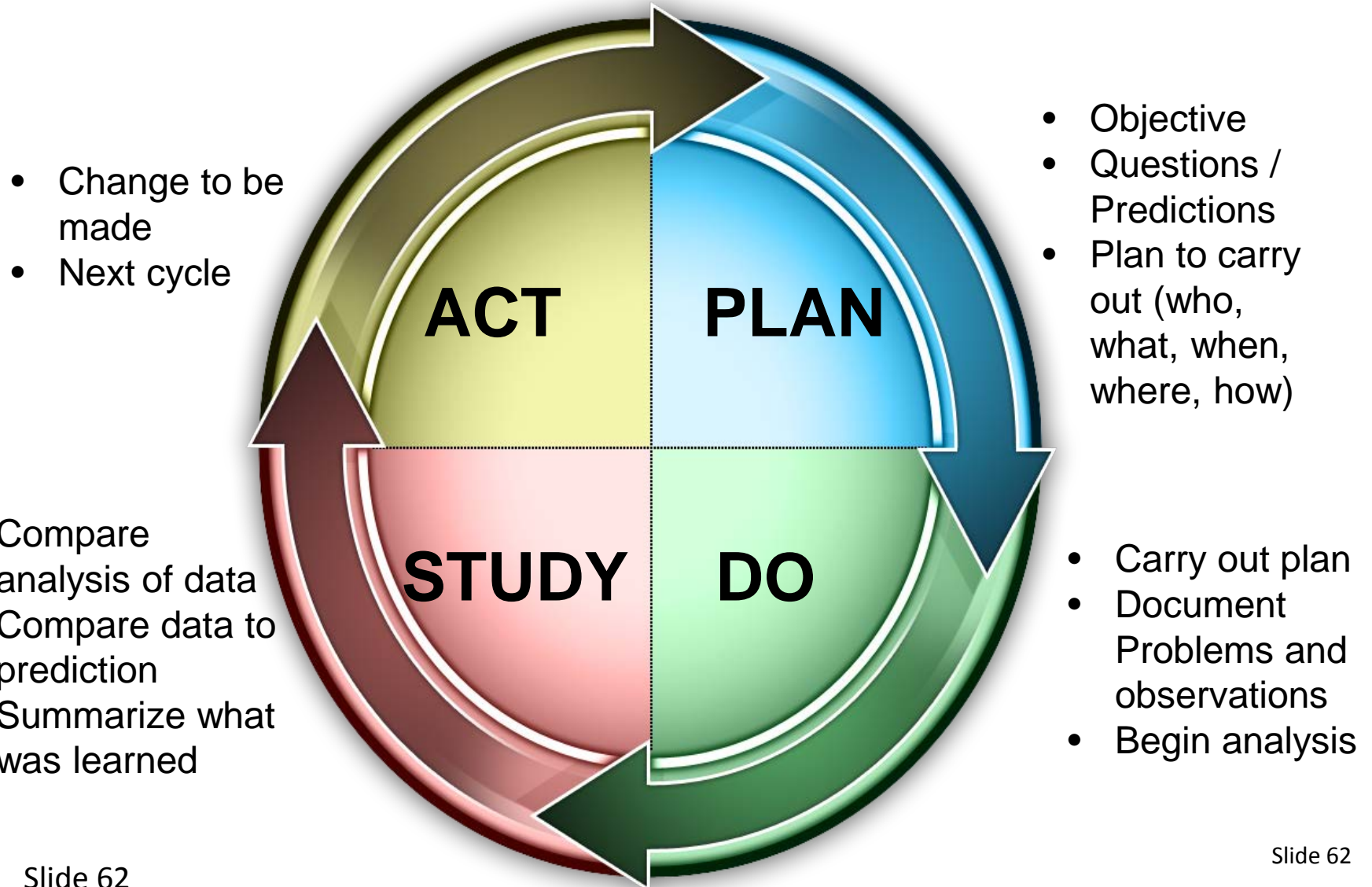
Prioritize Quality Opportunities and Charter PIPs

- Charter PIP Teams for like citations
 - Involve others and gather data
 - Develop preliminary POC steps
 - Reports back to the IDT no less often than weekly
 - Important assignment that team members and their supervisors must take seriously.

Plan. Conduct and Document PIPs

- Use a problem solving model like PDSA (Plan-Do-Study-Act).

PDSA Cycle



Past Compliance

Good News!

Overview

- Past noncompliance may be cited on Health and Life Safety Code surveys of nursing homes.
- Past noncompliance may be cited on any type of survey (standard recertification, abbreviated standard, e.g., complaint and revisit).
- Data about past noncompliance tags are not carried forward to subsequent revisit surveys.

Overview

- IDR will be allowed for past noncompliance tags
- May not IDR using the basis that, while it occurred, it should have been considered Past Noncompliance

Determination of PNC

- Three criteria must be met:
 - The facility was not in compliance with the specific regulatory requirement(s) (as referenced by the specific F-tag or K-tag) at the time the situation occurred;
 - The noncompliance occurred after the exit date of the last standard recertification survey and before the survey (standard, complaint, or revisit) currently being conducted; and

Determination of PNC

- Three criteria must be met:
 - There is sufficient evidence that the facility corrected the noncompliance and is in substantial compliance at the time of the current survey for the specific regulatory requirement(s), as referenced by the specific F-tag or K-tag.

Determination of PNC

- To cite past noncompliance there must have been a
 - Violation after the last standard survey
 - Evidence that it was corrected before the current survey event
 - Currently in compliance with the same regulatory requirement.

Determination of PNC

- Variety of methods to determine whether correction of the past noncompliance occurred and continues.
 - Interviews with facility staff, such as the administrator, nursing staff, social services staff, medical director, **quality assessment and assurance committee members**, and/or other facility staff, as indicated, to determine what procedures, systems, structures, and processes have been changed.

Determination of PNC

- Variety of methods to determine whether correction of the past noncompliance occurred and continues.
 - Reviewing through observation, interview and record review, how the facility identified and implemented interventions to address the noncompliance.

Determination of PNC

- Evaluating whether the facility has a functioning QAAC, whose responsibilities include
 - Identification of quality issues;
 - Providing timely response to ascertain the cause;
 - Implementing corrective action;

Determination of PNC

- Evaluating whether the facility has a functioning QAAC, whose responsibilities include
 - Implementing monitoring mechanisms in place to assure continued correction and revision of approaches as necessary to eliminate the potential risk of occurrence to other residents and to assure continued compliance.

Vickie's Understanding

- The Basics of PNC
 - Facility must have identified violation at or near the time it occurred,
 - Occurred after the last standard survey
 - Current survey information must indicate the facility is in compliance with same tag,
 - Correction action was taken (the four step POC) and completed before current survey.

Enforcement

- Recommend the imposition of a CMP for past noncompliance cited at the level of immediate jeopardy.
 - Per-Day
 - Per-Instance CMP: when it is difficult to accurately establish when the past noncompliance occurred

Enforcement

- A civil money penalty is the only applicable enforcement action for a past noncompliance cite.

Vickie's Understanding

- If PNC is D-I, then no citation, no 2567 entry, no CMP.

Lessons Learned

- Facility must be in compliance with the entire F-tag at the time of survey for an event to be reviewed as Past Noncompliance
- If event and root causes are addressed and resolved by PNC, but another practice results in noncompliance; the original event becomes part of the citation

Resources

- CMS Survey and Certification Letter 06-01. Downloaded July 10, 2016 from <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/SCLetter06-01.pdf>
- Bureau of Health Care Services, Department of Licensing and Regulatory Affairs (LARA). April 4, 2013. GUIDELINES FOR THE DEVELOPMENT OF A PLAN OF CORRECTION (POC) FOR LONG TERM CARE FACILITIES
- Presentation at Joint Provider Training in April 2011 by BHCS. Downloaded on July 10, 2016.
http://s.michigan.gov/search?q=past+noncompliance&site=som&btnG=Search&client=som&output=xml_no_dtd&proxystylesheet=som_frontend&oe=UTF-8&ie=UTF-8&num=10&lr=&sort=date%3AD%3AL%3Ad1&wc=200&wc_mc=1&ud=1&exclude_apps=1



INVOLUNTARY TRANSFERS OR DISCHARGES: THE REGULATIONS

JERRY A. BARKOFF, LMSW, ACSW
MANAGER, FEDERAL SURVEY AND
CERTIFICATION DIVISION

SEPTEMBER 2016 JOINT PROVIDER TRAINING



LTC - Involuntary Transfer/Discharge Process

What Constitutes a Transfer?

The term "Transfer" means the movement of a resident from one licensed facility to another, or in certain situations the movement from one certified distinct part of a facility to another certified distinct part of the same facility.



What Constitutes a Discharge?

The term "Discharge" means the movement of a resident out of a licensed facility regardless of the resident's final destination (i.e., home, family member residence, etc).

State Code and Applicable Administrative Rules Regarding Involuntary Transfers and Discharges

- Providers must comply with the following state requirements: Michigan Public Health Code:
 - MCL 333.21773 – Involuntary transfer or discharge of a patient
 - MCL 333.21774 – Resident right to appeal
 - MCL 333.21775 – Continuation of Medicaid funding during appeal
 - MCL 333.21776 – Transfer or discharge of patient, plan, counseling services



State Overview


Providers are required to review the State Rules and Codes to assure compliance.


The following highlights the procedure for involuntary transfers and discharges:





Notification to resident is required at least 30 days prior to involuntary transfer/discharge – Sec. 21773(2)


- Notice must be provided to the resident or responsible party (i.e., guardian, power of attorney) on the department ITD-502 form – Sec. 21773(3)


- 
- Copy of the ITD-502 form must be included in the resident's chart - Sec. 21773(5)
 - Notify the Bureau within 48 hours of the Notice being issued


- 
- Request for hearing ITD-505 form must be provided by the nursing home to the resident or responsible party (i.e., guardian, power of attorney) along with envelope and postage - Sec. 21773(3)

- 
- Resident has the right to request a hearing within 10 days following receipt of the notice – Sec. 21774(1)
 - Request for a hearing puts on hold the resident discharge/transfer - Sec. 21773(4)

- 
- If a hearing is requested, a hearing shall be held within 7 days and all parties will be notified by the agency responsible for the hearing - Sec. 21774(2)
 - Even if a hearing is not requested, the resident has the right to an orderly and safe transfer or discharge – Sec. 21776

- 
- Prior to any involuntary transfer or discharge, the nursing home must submit a ITD-512 check list to the Bureau. The Bureau will notify the nursing home via email or letter of the acceptance of the involuntary transfer/discharge plan.

- 
- The Bureau may request additional information if needed. The Bureau notification should be placed in the resident's record/file.




Please note that any discharge to a non-nursing home setting will require that the discharge plan clearly demonstrates that the proposed location offers, and has the ability to provide, the necessary services to meet the resident's needs.


F20 I

Transfer and Discharge Requirements


- **The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless--**




(i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;



(ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

- 
- (iii) The safety of individuals in the facility is endangered;
 - (iv) The health of individuals in the facility would otherwise be endangered;
 - (v) (iii) The safety of individuals in the facility is endangered;
 - (iv) The health of individuals in the facility would otherwise be endangered;

- 
- **(v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or**
 - **(vi) The facility ceases to operate.**

F202

Documentation

- **When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented...**

F203

Notice Before Transfer

- **Before a facility transfers or discharges a resident, the facility must...**



F204

Orientation for Transfer or Discharge

- A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

Contact Information

**Bureau of Community and Health Systems
Attn: LTC Involuntary Transfer/Discharge
Notice**

**611 W Ottawa Street
Lansing, MI 48909
P.O. Box 30664**

**Bureau Main Phone: 517-335-1980
Division Main Phone: 517-241-2638
FAX: 517-241-2635**

Division E-Mail: bchs-help@michigan.gov



Getting to the Root of the Problem an Ombudsman's Perspective

Dakima Jackson, MHSA
Certified Local Long Term Care Ombudsman



Does the resident/family member understand what's going on?

F204

§483.12(a)(7) Orientation for Transfer or Discharge

- A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

Let's Look at the Root Cause of the Problem

What is a Root Cause Analysis?

- RCA is a structured facilitated team process to identify root causes of an event that resulted in an undesired outcome and develop corrective actions. The RCA process provides you with a way to identify breakdowns in processes and systems that contributed to the event and how to prevent future events (QAPI).
- Root cause analysis helps identify what, how and why something happened, thus preventing recurrence

(Rooney J. James and Vanden Heuve Lee N.).

What's an involuntary discharge and what's not an involuntary discharge

- Reasons for Discharge (stated earlier)
- Improper reasons for discharge
 - The resident and/or family is difficult to deal with
 - The resident's Medicaid application is in process; and the facility has not been paid

How do we get to the root of the cause?

5 Why's the QAPI Way

- The resident received an involuntary discharge notice? **Why**
- The resident owes a substantial amount of money to the facility? **Why**
- The resident refuses to pay facility? **Why**
 - The guardians and/or responsible party have not paid resident bill? **Why**
- The resident states that she needs to give her son money? **Why**
- The resident states that her son needs help paying the bills? **Why**



What the Ombudsman does? A Person Centered Approach

- We speak to the resident / legal representative and if the resident/legal representative would like ombudsman to advocate then we will.
- We begin by asking questions and gathering facts. **Why and What's happening now**
- We engage the resident by asking the question what they (the resident) would like to their outcome to be.
- We ask the resident about the barriers they face and how to move past the barriers.
- We engage the facility staff by asking questions about what they know about the resident issues.
- We want to ensure the resident have a safe discharge and are informed on their rights

Through discovery

- If the resident has no income --then we engage the facility Social Service staff in assisting the resident with filing for SSI/SSD for eligibility.
- We engage the MDS department to review the MDS/LOCD with the resident to understand the determination process and explain what is medically necessary through the eyes of Medicaid.
-
- We may contact local community agencies on the resident's behalf to assist with other community benefits. (**referral to MI Choice Waiver program**)
- We may contact Adult Protective Services on behalf of the resident. Misappropriation of funds by a family member
- We may assist the resident in appealing the Involuntary Discharge

Questions to ask.... Fact Checking,--- Information and Education- A Person Centered Approach

- What do we know about the resident who was just admitted to your facility?
- During the admission process was the resident informed of services cost and public benefits available? Medicaid –up to 45 days , Medicare up to 100 days
- How was the resident informed and by whom? Admissions, social worker, etc....
- When was the resident informed about the involuntary discharge? Day, night , weekend
- Was the resident overwhelmed by the information and/or did they go through a major procedure and is incoherent?
- How was the billing information provided and in what format?



Questions to ask.... Fact Checking,--- Information and Education-A Person Centered Approach

- Is the resident really aware of the consequences for not paying their nursing home bill?
- Have the facility provided counseling to the resident in regards to paying the nursing home bill?
- Does the resident have an unmet need that is not being met?
- Does the family understand elder abuse= misappropriations of funds = elder abuse?
- Does the resident need a conservator?
- Does the resident need a representative payee?

Helpful Suggestions

- Review of admission forms?
- Review what's happening during the admissions process- the day and time of admission, is resident oriented, are they in pain.....
- Conduct a fact finding interview process
- Reach out to your local Area Agency on Aging for Community Resources
- Reach out to your local Centers for Independent Living Agencies (younger disabled residents)
- Reach out to your local Community Mental Health Agency
- Reach out to your local Ombudsman

Community Resources

- **Area Agencies on Aging** <http://mi-seniors.net/regionmap/>
- **AFC/ Homes for the Aged website** http://www.dleg.state.mi.us/brs_afc/sr_afc.asp
- **Centers for Independent Living 's** <http://www.virtualcil.net/cils/query-iandr.php?state=mi>
- **Community Mental Health Programs** http://www.michigan.gov/documents/cmh_8_I_02_37492_7.PDF
- **KNOW YOUR RIGHTS -- Your Medicaid Care And Coverage In A Nursing Facility**
http://www.michigan.gov/documents/mdch/Know_Your_Rights_handout_FINAL-08-DCH-73I_173347_7.pdf
- **Long Term Care Ombudsman 1-866-485-9393**
- **Medicare Booklet** <https://www.medicare.gov/Pubs/pdf/I1034.pdf>
- **Medicare and Medicaid Assistance Program 1-800-803-7174**
- **Nursing Facility Eligibility Booklet** http://www.michigan.gov/documents/nursing_fac_elig_134653_7.pdf

Citations

- Centers for Medicare and Medicaid Services (2011). QAPI **Guidance for** Performing Root Cause Analysis (RCA) with Performance Improvement Projects (PIPs) Retrieved from <https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/guidanceforrca.pdf>
- Centers for Medicare and Medicaid Services (Rev. 157, 06-10-16.) State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Retrieved from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf
- Centers for Medicare and Medicaid Services. (2011). QAPI Five Whys Tool for Root Cause Analysis Retrieved from <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/FiveWhys.pdf>
- James J. Rooney and Lee N. Vanden Heuve (JULY 2004.) Root Cause Analysis for Beginners Quality Progress Retrieved from https://www.env.nm.gov/aqb/Proposed_Regs/Part_7_Excess_Emissions/NMED_Exhibit_18-Root_Cause_Analysis_for_Beginners.pdf

Questions

????????????

Thank you 😊

Involuntary Discharge and Transfers

Practical Application in Long Term Care

K. Harrell, BS NHA, September 2016 Joint Provider Training

Learning objectives

- Learn the Provider requirements for issuing an Involuntary Discharge
- Understand situations that may warrant an Involuntary Discharge

Applicable F-tags

- ◆ F-201 §483.12(a)(1)(2) – Admission, Transfer, and Discharge Requirements
- ◆ F-202 §483.12(a)(3) – Documenting Resident Transfers and Discharges
- ◆ F-203 §483.12(a)(4)-(6) – Notification Requirements Before Transfer or Discharge of a Resident
- ◆ F-204 §483.12(a)(7) – Orientation for Transfer or Discharge

PUBLIC HEALTH
CODE
(EXCERPT)
Act 368 of 1978

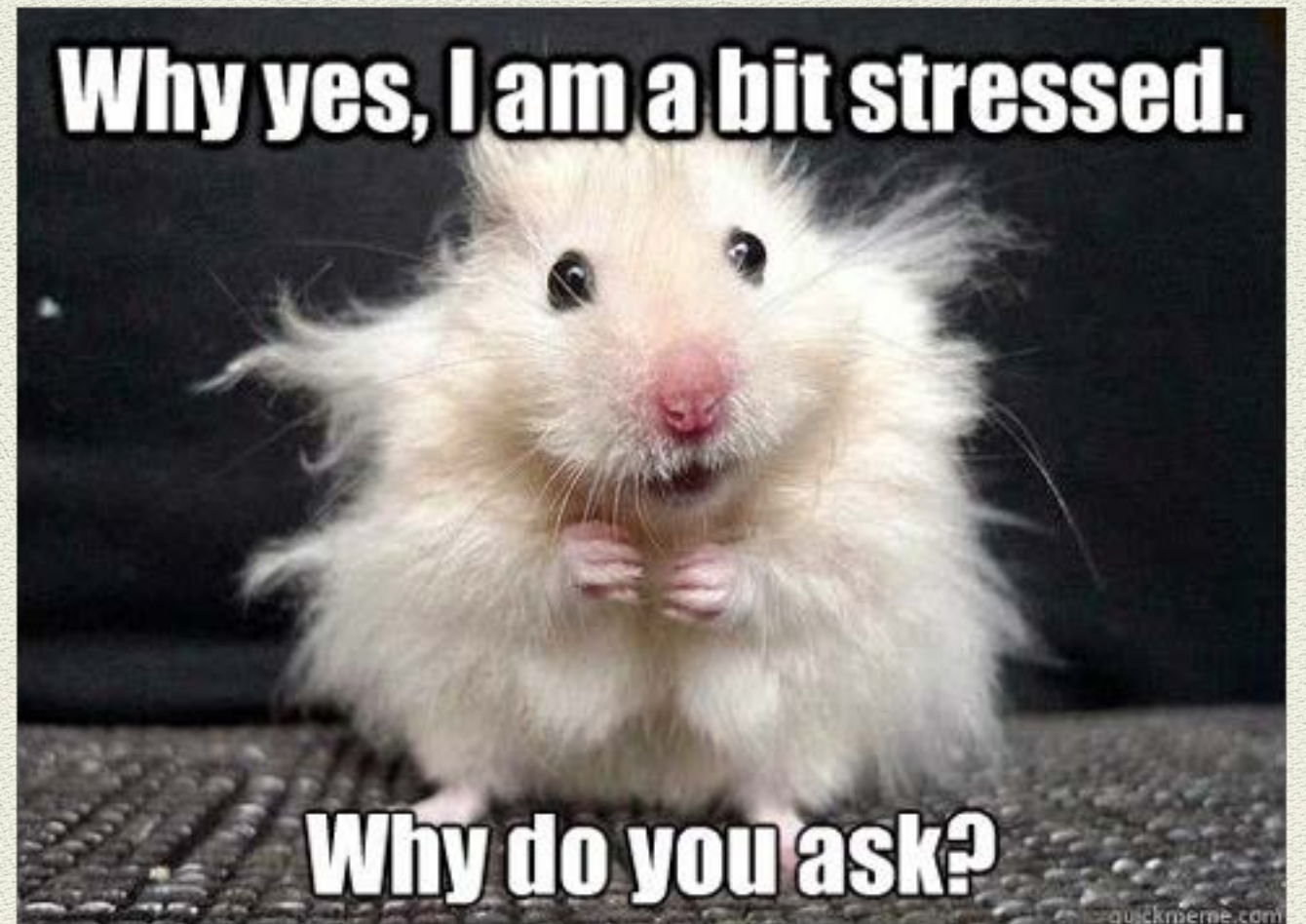
MCL 333.21773



- ♦ Sec. 21773.
- ♦ (1) A nursing home shall not involuntarily transfer or discharge a patient except for 1 or more of the following purposes:
 - ♦ (a) Medical reasons.
 - ♦ (b) The patient's welfare.
 - ♦ (c) The welfare of other patients or nursing home employees.
 - ♦ (d) Nonpayment for the patient's stay, except as prohibited by title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396r-6 and 1396r-8 to 1396v.

ITD Situations

*Scenarios Supporting
Involuntary Discharges*



- ◆ Medical Reasons
- ◆ Patients Welfare
- ◆ Welfare of Other Residents or Staff
- ◆ Non-payment

Medical Reasons

- Patient condition has changed requiring medical services not supported at the Center.
- Requires supporting physician orders and documentation.



Patient's Welfare

- Evidence to support why the residents welfare is at risk or resident presents a danger to self.



Welfare of Others

- ◆ Evidence documented in the clinical record supporting that other residents or staff may be at risk if the resident is not transferred or discharged.



Non-payment

- Failure to make payments on their accounts including failure to make patient pay amounts (PPA's) when the means to do so are present.



Issuing an IDT

- ◆ At least 12 point type
- ◆ Use ITD-502 form
- ◆ Serve to patient and legal representative.
- ◆ Copy in clinical record
- ◆ Notify Bureau within 48 hours of issuance

NOTICE OF INVOLUNTARY TRANSFER OR DISCHARGE		
DATE DELIVERED: September 20, 2016		
Resident Jane Doe	Guardian/Durable Power of Attorney (DPA) James Doe, Legal Guardian	
From (Nursing Home Administrator) Peter Administrator	Nursing Home Name Great Facility USA	
Nursing Home Contact Person Joe Doe	Contact Person Title Business Office Manager	
Nursing Home Address 1234 Maple Avenue	Contact Person's Telephone Number 555.555.5555	
City Anywhere	State Michigan	ZIP Code 48000
THIS NOTICE IS TO ADVISE YOU THAT:		
You will be transferred or discharged to: Community Placement		
Effective date of Transfer: October 20, 2016		
Reason for Involuntary Transfer/Discharge (MCL 333.21773): <input type="checkbox"/> Medical Reasons <input type="checkbox"/> Patient's Welfare <input type="checkbox"/> Welfare of Other Patients or Nursing Home Employees <input checked="" type="checkbox"/> Nonpayment for the Patient's Stay (see Section 21773(d))		
Explanation of Reason Above: Resident is not able to make personal/financial decisions for himself. His Guardian, James Doe has resisted discharge planning and has failed to provide necessary financial documentation to satisfy the requirements of a Medicaid application. Currently owes \$4000 which reflects private pay charges for 30 days. Medicare benefits exhausted on July 20, 2016. Guardian has been consistently uncooperative with attempts to secure a secondary payor source.		

LARA-BCHS-LTC-502 (REV 03/11/2016)
Authority: P.A. 368 of 1978 as amended
Page 1 of 2

The Michigan Department of Licensing & Regulatory Affairs will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs. You may make your needs known to this Agency under the Americans with Disabilities Act if you need assistance with reading, writing, hearing, etc.

Who gets the ITD Notice.

*Resident

*Resident's legal responsible party

*bchs-help@michigan.gov

*The ombudsman

Resident Rights

- Even if a hearing is not requested through the appeal process, the resident still has the right to an orderly and safe discharge.



Appeal?



Ever get that feeling
that today is going
to be a long day?

Provider Responsibilities:

- ◆ The request for hearing must be provided to the resident or responsible party along with envelope and postage.
- ◆ ITD-505 form must be used.
- ◆ Resident has 10 days from receipt of notice to request the hearing.
- ◆ The appeal request puts a hold on the discharge.

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU COMMUNITY AND HEALTH SYSTEMS

APPEAL OF A NOTICE OF INVOLUNTARY TRANSFER OR DISCHARGE

This form is request a hearing due to a Notice of Involuntary Transfer or Discharge. Request must be sent to the department within 10 days of the Notice. If you have questions, please call (517) 335-1980. Please type or print:

Resident Requesting Hearing:		
Address Where Resident Wants Hearing Correspondence Mailed To:		
City:	State:	Zip Code:
Resident/Guardian/DPA Daytime Telephone Number:		
Nursing Home Name:		
Nursing Home Address:		
City:	State:	Zip Code:
Date When Notice of Involuntary Transfer Or Discharge Was Received:		
Person Requesting Appeal (completion of this section acts as an electronic signature):		
Person requesting a hearing must be one of the following: <input type="checkbox"/> Resident <input type="checkbox"/> Durable Power of Attorney (DPA) for Resident <input type="checkbox"/> Guardian of Resident		
Return completed form to: Michigan Department of Licensing and Regulatory Affairs Bureau of Community and Health Systems Request for Hearing – Involuntary Transfer/Discharge P.O. Box 30664 Lansing, MI 48909 (Street Address: 611 W. Ottawa Street, Lansing, MI 48933) FAX: (517) 241-2635 bchs-help@michigan.gov (Subject Line: LTC Request for Hearing)		

What happens during the hearing?

- Usually a phone conference. Can be held in person at the facility.
- Provide a copy of all supporting documentation to the Administrative Law Judge, and the patient. Assemble all witnesses, as they will have to testify.
- Patient may have their legal representative or advocate present.
- Be able to concisely explain through your opening statement the reason for the Notice.

Safe Discharge

- ♦ Importance of early discharge planning.
- ♦ Form ITD 512 must be completed and submitted to the state for approval and maintained in the clinical record.
- ♦ Keep the care plan updated and notes re: status.

The word "DOCUMENTATION" is written in a bold, black, handwritten style. A long, sweeping horizontal flourish extends from the bottom of the word.

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
P.O. BOX 30664, LANSING, MI 48909
Phone: (517) 335-1980 FAX: (517) 241-2635 Email: bchs-help@michigan.gov

FACILITY INVOLUNTARY TRANSFER/DISCHARGE PLAN

Resident Name		Nursing Home Facility Name	
Resident's Guardian/Designated Representative		Telephone Number	
Street Address	City	Zip Code	
Date(s) counseling provided to resident prior to transfer/discharge:			
Person that Provided Counseling	Title	Telephone Number	
Receiving Facility Name			
Date Resident/Guardian Visited Receiving Facility:			
<input type="checkbox"/>	Alternative: Resident/guardian received appropriate information about the receiving facility such as brochure, floor plan, and pictures to familiarize the resident with the new facility.		
<input type="checkbox"/>	Alternative: Site visit was waived in writing by physician, resident, or guardian.		
Date Resident Will Move to New Facility:			
Guardian/family member will accompany resident during move: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Person providing counseling within 72 hours of transfer/discharge:		Title:	Telephone Number:
Signature of Facility Representative		Title	Date
Name of Resident/Guardian/Family Representative		Relationship to Resident	
Signature of Resident/Family Representative			Date
Attach a list of medical needs of resident (i.e., oxygen, tube feedings, catheters, medications, etc.).			
Attach a list of the medical conditions of resident (i.e., wheelchair bound, para/quadruplegic, etc.).			
Attach physician statement indicating how resident's condition and needs will be accommodated during the transfer/discharge and in the new placement.			

Send Involuntary Transfer/Discharge Plan to address above for department review prior to move.

The plan must clearly demonstrate that the proposed location can meet the needs of the resident.

Document Everything!

Case study

- Resident admitted as a short stay resident under Medicare . Made progress in therapy and reached maximum potential. Discharge scheduled. Orders written. Home health set up. On day to go home, stalled stated "not ready to go." Receives social security, pension and annuities. Refuses to participate in further discharge but refuses to pay towards cost of stay. Approaching one month of nonpayment. Reports charges are too much and Insurance should be covering. Son resides in residents home with live-in girlfriend & picks up resident frequently to take her for shopping trips and to the bank "pay bills", in which she transfers in/out of the car independently. Alert and oriented x3, no cognitive deficits.

Proactivity

- ◆ Admissions checklist, discussion of finances and charges early on
- ◆ Early discharge planning, Home Evals
- ◆ Resident Education/Conference
- ◆ Notice of Non-Coverage, Level of Care Determination
- ◆ Community resource connections
- ◆ Representative payee/conservator ship/guardianship

Placement Options

- ◆ Another SNF
- ◆ AFC facility
- ◆ Community Placement
- ◆ Short term residential

Questions

Forms:

http://www.michigan.gov/documents/lara/BCHS-LTC-502_ITD_Notice_516997_7.pdf

http://www.michigan.gov/documents/lara/BCHS-LTC-505_ITD_Hearing_Request_517007_7.pdf

http://www.michigan.gov/documents/lara/BCHS-LTC-512_Facility_ITD_Checklist_516995_7.pdf