Carrying the Torch and Establishing Key Nursing Leadership Competencies
Sara Elizabeth Hamm, RN, BSN, MS, CDP, FACDONA
Vice President of Successful Aging and Health Services

Are You a Leader or a “Boss”/Manager?
- Personal leadership inventory
- Nursing history
- Personal history & biases
- Important mentors
- “Difficult” bosses
- Visionary or “we’ve always done it this way!”
- True passion to lead or you were promoted against your will

History of Nursing
- Female oriented & not respected
- Health care & medicine remain largely patriarchal
- Don’t get mad at me: Least educated of all health care professionals
- “Eat our young” (Bullying)
- Promotions based on clinical competency
- Largely focused on acute care
Essential Leadership Traits

• A true desire to “LEAD” and develop others
• Communication & collaboration
• Visionary outlook: Be INNOVATIVE!!
• Lack of EGO & professionalism
• Knowledge & expertise but open to learn from others
• Always hire people smarter than you!
• Critical need for nursing research & evidence-based practice

Nursing Theories & Leadership Styles

• Autocratic – Gives orders & directives
• Democratic – Gathers input from others
• Laissez Faire – “Hands-Off” & no guidance
• Transactional – Rewards & punishments
• Transformational – Example & optimism

True transformational leaders strive to create other leaders.........

The Nurse Leader’s Role in Strategic and Succession Planning

• Have a plan
• Develop your plan
• Make sure it is part of the organizational plan
• Develop YOU, your people, and your team
• Look for team members smarter than YOU!
• Constantly strive for innovation
• Find and utilize a leadership mentor
• Have fun!!
Clinical Strategic Plan
Strategy Section for 2017

• Improve care/occupancy/revenue by developing clinically sound, market driven services
• Become a nationally respected memory provider thru innovative programs & partnerships
• Continue to increase efficiency & outcomes thru standardized “best practices”
• Decrease hospital readmission rates and decrease LOS thru innovative care transitions
• Improve regulatory compliance/CMS 5-Star ratings thru routine analysis of Q-Metrics
• Support growth of RW teams to expand profitable services and promote increased RLOS
• Active participation in AADNS, NADONA, NCCHP, Leading Age, & NEC

“Nurses Eat Their Young”- Create a ZERO Tolerance for Bullies

• Research on lateral violence and bullying among nurses
• Losing great clinicians due to nursing bullies
• What can we do to end the cycle?
• Create an environment of support and learning
• Celebrate successes publicly
• Discipline and coach privately

“Nurses Eat Their Young……”

• You-Tube Video Clip from the American Nurses Association
Nursing & Professionalism

- Verbal communication and body language
- Self-confidence
- Written communication & use of email
- Professional attire & dress code in your organization
- Professional organizations & continued growth

Interdisciplinary Team Work

- Real leaders never work in silos
- Watch relationships between Ops, sales, and nursing
- NEVER publically disparage your partners & leadership team members
- Become a “nurse and business partner”

The Impact Strong Nursing Leadership Can Have on Aging.............
Importance of Reactivity In Work and Relationships
Leadership Implications

DEBRA HAGERTY DNP, NHA, CDP, ACDDCT, IP-BC, LBSW, CDONA, FACDONA

OBJECTIVES
1. Learner will define and discuss reactivity and its impact on the relationship with the boss.
2. Discuss tools to promote relationship building and diminish reactivity in the workplace.
3. Review Active Telling, Active Listening, and Dialogue as a relationship building tools.

REACTIVITY CAUSES

VUCA
- Volatility
- Uncertainty
- Complexity
- Ambiguity
Reactivity Definition

Reactivity is behaviors not helpful to and not aligned with producing desired outcomes.

CONTRIBUTING FACTORS TO REACTIVITY

- Fear of unknown-Daily
- Skills not proficient-New expectations-Daily
- Relationships with staff need to be developed-Takes time
- Constant changes-QAPI
- Constant emotions in flux-Stress and excitement

REACTIVITY IS HUMAN AND NORMAL

OUR BRAINS ARE HARDWIRED TO REACT

- Minor slips in communication with boss-Cause reactivity
- Or a chain reaction of misunderstandings-boss
- Work emotions and work relationship stress-boss
Reptilian Brain

Hardwired to React

AUTONOMIC STRESS RESPONSE
- Hardwired into our humanness.
- Experience and skill & Education Do Not protect us
- Stress factors cause us to act counter productive, Pull us from using our best skills!

UNPROFESSIONAL BEHAVIORS
- Counterproductive
- Happens no matter how skilled, smart, or experienced we are.
- We do not see how we appear to the students or others.
TAKE A MINUTE TO DISCUSS

Turn to the person on the right
Tell them about the last time you were reactive. Then they tell you the same.

➢ Serious discussion with someone
➢ Someone upset you

IMPROVE COMMUNICATION IS KEY
Starting point is looking at things the way they are!!

What seems like:

- Personality Issues
- Lack of Skills
- Not caring
- Severe Dysfunction

Situational factors
Temporary Degradation of Skills
Due to Complexity and Stress

Reactivity
Creativity

Judgment, blame, Personality diagnoses
Personal accountability, What’s working and not working
Pushing ideas or withdrawal into silence
Joint exploration of all ideas
Unbalanced participation
Balanced participation

Stuck in conflict or no conflict
Decisions premature or delayed
Conflict surfaced and managed
Balanced dialogue and decision making
FRAMEWORK FOR RELATIONSHIP BUILDING

• Active Telling
• Active Listening
• Checking Understanding
• Check for Reactivity
• Reflection

ACTIVE TELLING

➢ People are likely to get on board with an idea if they have an opportunity to talk about it

➢ Express concerns

➢ A large majority of people have to talk their way to commitment over multiple conversations

Skillful Telling

➢ ASK Permission
➢ TELL Use I Statements
➢ ASK Ask What Was Heard-Summarize
Active Telling

- Driven by a need for success
- Need to convince people of my ideas.
- Worked hard to present ideas in a powerful and inspirational way, minimizing weaknesses and flaws
- Well-prepared and could quickly counter any perceived limitations or risks.

Paradox of Active Telling

- Even the most inspirational speech is lucky if it gets even 20% of people on board
- The large majority of people have to talk their way toward commitment over multiple conversations.
Dialogue

- State your intention to first understand even if there is disagreement.
- Be vigorous in assuring accurate learning about different viewpoints by avoiding debates.
- Repeatedly summarize and check for understanding.

Reflection

- Set aside certainty that there is ONE correct viewpoint (no matter how certain you are).
- Prepare to state your view with the aim of being understood, not “getting” agreement.
PUSHING FOR A SOLUTION IS NOT THE SOLUTION

➢ Without an understanding we close off exploration of ideas with others

➢ Don’t consider right versus wrong or good versus bad.

SYSTEMS SOLUTIONS MINDSET

Supports Creativity

➢ What Are The Facts?
➢ Am I a Judger?
➢ How Did We Contribute To The Problem?
➢ What Outcomes Do I Want?

FROM OBSERVATION TO BELIEF

The Ladder of Inference
Reactive Mindsets

- Dominating Push is Survival
- Close Off Exploration of Ideas
- In Order To Fix Things

What recent activity caused you to feel reactivity??

What was the reactivity about??

Who was it with??
Opportunities for Reactivity at Work

a. Failure to understand?
b. Not enough time?
c. Given additional duties you not aware of?
d. Disagree with approach to staff problems.

Solutions To Reactivity and Communication Barriers

TEAMWORK

PRACTICE REFLECTION
FEEDBACK

Morning Meeting

End of Shift report

HOW DID WE DO???

Techniques to Improve the Relationship with the Boss

1. Develop a trusting relationship
   a. Do what you say you will
   b. Don’t blindside with events
   c. Remember No I in Team
Nursing Director Versus IHI Data

1. When you experience problems with improvement and safety initiatives, estimate the frequency that the predominant cause is due to relational issues. Write in a number from 1 (almost never) to 5 (almost always)—see table below—Your estimate.

<table>
<thead>
<tr>
<th>Relational Issues</th>
<th>Nursing Director</th>
<th>IHI RNs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Almost Never</td>
<td>38</td>
<td>110</td>
</tr>
<tr>
<td>Never</td>
<td>54.9%</td>
<td>89.1%</td>
</tr>
<tr>
<td>Rarely</td>
<td>23.9%</td>
<td>38.2%</td>
</tr>
<tr>
<td>Occasionally</td>
<td>23.9%</td>
<td>38.2%</td>
</tr>
<tr>
<td>Frequently</td>
<td>23.9%</td>
<td>38.2%</td>
</tr>
</tbody>
</table>

2. I am currently facing a challenging situation in which I see reactivity in myself and/or others. Improving this situation would make a significant impact on my work life. (check one)

- Yes
- No
- Uncertain

The above situation has been going on for roughly (check one)

- Days
- Weeks
- Months
- 6 months – 1 year
- >1 to several years

<table>
<thead>
<tr>
<th>Days</th>
<th>Weeks</th>
<th>Months</th>
<th>6 months – 1 year</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>25%</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>10%</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>5%</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
</tr>
</tbody>
</table>
THE ABOVE SITUATION HAS BEEN GOING ON FOR

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Debra RNs</th>
<th>IHI RNs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days</td>
<td>97</td>
<td>146</td>
</tr>
<tr>
<td>Weeks</td>
<td>4.1%</td>
<td>3.7%</td>
</tr>
<tr>
<td>Months</td>
<td>10.9%</td>
<td>6.9%</td>
</tr>
<tr>
<td>6 mos – 1 year</td>
<td>28.9%</td>
<td>34.9%</td>
</tr>
<tr>
<td>Years</td>
<td>23.7%</td>
<td>23.3%</td>
</tr>
</tbody>
</table>

3. The most important barriers to my own personal reflection are:

- Lack of time: 61.1% Debra RNs, 62.2% IHI RNs
- Lack of sufficient organizational support: 31.0% Debra RNs, 38.7% IHI RNs
- Lack of availability of colleagues: 10% Debra RNs
- How to do it: 25.7% Debra RNs, 32.4% IHI RNs
- Lack of feedback: 20.4% Debra RNs, 37.8% IHI RNs
- Other (please describe):

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Debra RNs</th>
<th>IHI RNs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of time</td>
<td>61.1%</td>
<td>62.2%</td>
</tr>
<tr>
<td>Lack of support</td>
<td>31.0%</td>
<td>38.7%</td>
</tr>
<tr>
<td>Availability</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>How to do it</td>
<td>25.7%</td>
<td>32.4%</td>
</tr>
<tr>
<td>Lack of feedback</td>
<td>20.4%</td>
<td>37.8%</td>
</tr>
<tr>
<td>Other</td>
<td>3.5%</td>
<td>11.7%</td>
</tr>
</tbody>
</table>

NORMS

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Yes</th>
<th>No</th>
<th>Uncertain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Debra RNs</td>
<td>81.5%</td>
<td>13.0%</td>
<td>5.6%</td>
</tr>
<tr>
<td>IHI RNs</td>
<td>79.4%</td>
<td>20.6%</td>
<td>0%</td>
</tr>
<tr>
<td>Yes</td>
<td>61.4%</td>
<td>27.3%</td>
<td>11.4%</td>
</tr>
<tr>
<td>No</td>
<td>38.9%</td>
<td>60.0%</td>
<td>0%</td>
</tr>
<tr>
<td>Uncertain</td>
<td>61.4%</td>
<td>27.3%</td>
<td>11.4%</td>
</tr>
<tr>
<td>FREQUENCY</td>
<td>Almost Never</td>
<td>1-25% of Time</td>
<td>26-50% of Time</td>
</tr>
<tr>
<td>-----------</td>
<td>--------------</td>
<td>----------------</td>
<td>----------------</td>
</tr>
<tr>
<td>1. The leaders in my organization are aligned on priorities.</td>
<td>4.0</td>
<td>3.0</td>
<td>4.0</td>
</tr>
<tr>
<td>2. When a decision is needed, it is clear who has the authority to make it.</td>
<td>4.0</td>
<td>3.2</td>
<td>4.0</td>
</tr>
<tr>
<td>3. People who are likely to be impacted by a decision are consulted for input prior to the final decision.</td>
<td>3.3</td>
<td>3.1</td>
<td>3.0</td>
</tr>
<tr>
<td>4. After decisions are made, leaders meet with those people impacted to explain the rationale, seek input, and instigate buy-in to implementation.</td>
<td>3.5</td>
<td>3.2</td>
<td>3.0</td>
</tr>
<tr>
<td>5. When people communicate or behave in ways which impair collaborative teamwork, they receive feedback and are expected to make changes.</td>
<td>2.8</td>
<td>3.1</td>
<td>3.0</td>
</tr>
<tr>
<td>6. When resistance occurs, it is heard through dialogue which emphasizes problem solving and it does not stall decision making or forward progress.</td>
<td>3.0</td>
<td>3.2</td>
<td>3.0</td>
</tr>
<tr>
<td>7. When difficult conversations are needed, people are willing to take them on and work hard to resolve issues without blaming or judgment.</td>
<td>3.0</td>
<td>3.2</td>
<td>3.0</td>
</tr>
<tr>
<td>8. When conflict, people take care to hear and explore each point of view (e.g. as opposed to talking over each other or engaging in win-lose debates).</td>
<td>3.0</td>
<td>3.2</td>
<td>3.0</td>
</tr>
<tr>
<td>9. Meetings are productive.</td>
<td>3.2</td>
<td>3.0</td>
<td>3.0</td>
</tr>
<tr>
<td>10. Physicians are aligned and actively engaged with improvement efforts.</td>
<td>3.2</td>
<td>3.0</td>
<td>3.0</td>
</tr>
</tbody>
</table>

**Final Tool to Diminish Reactivity**

Establish a Culture Where People Can Say What They Think!!

**Culture of Cooperation and Collaboration**

1. Not your problem and my problem
2. People communicate with Vision
3. Fear is not a part of my sense at work
4. Team building is a priority
5. Safety is first
6. Quality Assurance and Improvement is continuous
Summary

- Reactivity is a Normal Event / Destructive to student learning
- Awareness of the role of reactivity is important
- Culture of Open and Honest Discussion should be taught where people can say what they think.

References


Collaborative Approach to Improving Care and Reducing Readmissions

Edna Clifton, MBA, BSN, RN
Associate Director, Care Coordination
Health Services Advisory Group (HSAG)
March 14, 2017

Presentation Objectives

- Identify the focus of Quality Innovation Network’s (QIN’s) work.
- Define the CMS strategy goals.
- Recognize where Florida’s readmission rates rank with the nation’s rates.
- Examine the goals of community coalitions.
- Identify projects that have successfully reduced readmission rates.

CMS Quality Strategy Goals

Better Care, Healthier People, Healthier Communities, Smarter Spending

**Health and Human Services’ (HHS) Efforts to Improve Healthcare**

**Tying payment to value through alternative payment models**

- **85%** of all Medicare fee-for-service (FFS) payments tied to quality or value by 2016
- **30%** through alternative payment models by the end of 2016
- **90%** of all FFS payments tied to quality or value by 2018
- **50%** through alternative payment models by the end of 2018


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**Policy Development**

- Comprehensive Care for Joint Replacement, Coronary Bypass Grafts, Acute Myocardial Infarction, and Cardiac Rehabilitation
- Proposed Rule for Discharge Planning
- Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) and Value-Based Purchasing (VBP) for Skilled Nursing Facilities (SNFs)

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**Medicare’s Call for Action to Communities**

- Build and sustain community coalitions focused on improving coordination of care between settings.
- Strengthen communication with community coalition partners in an open, non-competitive forum.
- Reduce hospital readmission rates for Medicare FFS patients by 20% by 2019.
- Improve medication safety to prevent adverse drug events that contribute to significant patient harm.
QIN-QIO Areas of Focus

Cardiac Health
Disparities in Diabetes
Support of Clinicians in the Quality Payment Programs
Antibiotic Stewardship in Communities
Coordination of Care
Value-Based Purchasing Program
Healthcare Acquired Conditions in Nursing Homes
Patient is at the center of care

What are the Readmission Rates?

Readmission Definition

“We define a readmission as a subsequent inpatient admission to any acute-care facility which occurs within 30 days of the discharge date of an eligible index admission.”

Florida State 30-Day Readmissions Ranking
January 1–December 31, 2015

We are here

Why All the Talk About Readmissions?

- Poor care coordination and use of evidence-based approaches
- Large number of readmissions are preventable

Quality

- Institute of Medicine (IOM) reports made clear the consequences of poor transitions management

Safety

- Centers for Medicare & Medicaid Services (CMS) indicate $138B in savings or $25B across all U.S. payers

Cost

How Can We Reduce Readmissions?
The Care Coordination Solution

Care Coordination Coalitions

The Building Blocks of a Community Coalition
Community Essentials

- Developed around collaborative care delivery
- Shared vision
- Shared mission
- Shared resources
- Shared decision making
- Environment of trust

Care Coordination

- Establish coalitions to bring providers together to coordinate efforts to support the CMS call to action measures
- Assist coalitions to identify the root cause of their readmissions
- Analyze processes to identify gaps which cause the failure to achieve a smooth transition from one level of care to the other
- Develop interventions to correct the issues
- Measure effectiveness of the intervention
- Modify processes
- Re-measure

Best Practices
## Best Practices: Program to Enhance Communication to Avoid Readmissions

**Osceola Community**

<table>
<thead>
<tr>
<th>Issue</th>
<th>Patients were being sent from the skilled nursing facility (SNF) to the emergency department (ED) for an issue and it was not clearly communicated to the ED why the patient was sent there.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dilemma</td>
<td>With incomplete information, the ED treated the patient based on diagnosis and emergency medical services (EMS) information.</td>
</tr>
<tr>
<td>Solution</td>
<td>The SNF community collaborated with local ED physicians to identify critical information needed to appropriately treat the patient for that episode.</td>
</tr>
</tbody>
</table>

## SNF to ED Transfer Communication Sheet

- [Communication Sheet Image]

## Best Practices: Programs to Divert Readmissions to Appropriate Providers

**Jacksonville Community**

<table>
<thead>
<tr>
<th>Issue</th>
<th>Dialysis patients were presenting in the ED with fluid overload because of missed treatments.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dilemma</td>
<td>Hospitals cannot dialyze patients on an outpatient basis.</td>
</tr>
<tr>
<td>Solution</td>
<td>The hospital reached out to a nearby dialysis center to negotiate chair times for these patients and averting a readmission.</td>
</tr>
</tbody>
</table>
Best Practices: Programs to Divert Readmissions to Appropriate Providers (cont.)

Brevard Community

**Issue:** Patients discharged to home often become overwhelmed with changes in treatments and medications and tend to return to the ED for assistance.

**Dilemma:** The patients are often readmitted because of adverse drug events and/or changes in their condition due to failure to follow treatment plans.

**Solution:** Patients who had been transported by emergency medical services (EMS) to the hospital for their initial admission had follow-up visits from EMS within 8–24 hours of their discharge. Treatment and medications were reviewed and the patients’ living conditions were assessed for community services. Providing this support reduced hospital readmission.

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Top 10 Evidence-Based Interventions

1. Enhanced admission assessment
   - Begin discharge planning on admission
2. Formal assessment of risk of readmission
   - Align interventions to patient’s needs
3. Accurate medication reconciliation at:
   - Admission
   - Any change of level of care
   - Discharge
4. Patient education
   - Assess health literacy

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Top 10 Evidence-Based Interventions (cont.)

5. Identify primary caregiver
6. Use teach-back to validate understanding
7. Send discharge summary within 24–48 hours
8. Collaborate with post-acute care and community
9. Schedule follow-up appointments before discharge
10. Conduct post-discharge follow-up calls within 48 hours of discharge

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Coming together is a beginning. 
Keeping together is progress. 
Working together is success. 

–Henry Ford

Thank you!

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EClifton@hsag.com
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Cell: 813.753.5379
Learning Objectives

1. Understand the magnitude and the impact of preventable hospital readmissions
2. Know the state-specific priorities for preventable acute care readmissions
3. Identify the “best practice” strategies for reducing preventable acute care readmissions

Why Focus on Readmissions?

- A patient readmitted soon after a hospitalization reflects a failure to return that individual to health
  - Poor transitions in care
  - Lack of patient and caregiver understanding
  - Inefficiencies in the system
  - Ineffective or lack of communication
  - Poor quality of care
Why Focus on Readmissions?

- Readmissions are costly
  - Estimated $15 billion in Medicare costs per year
  - Florida data shows
    - CHF - $278.7 million
    - AMI - $59 million
    - Pneumonia - $130.2 million
    - CABG - $60.7 million
    - Hip replacement - $74.2 million

Florida Ranking

<table>
<thead>
<tr>
<th>State</th>
<th>Percent Change</th>
<th>Read. Reduced</th>
</tr>
</thead>
<tbody>
<tr>
<td>FL</td>
<td>-2.70%</td>
<td>-3,161</td>
</tr>
<tr>
<td>TX</td>
<td>-8.70%</td>
<td>-2,905</td>
</tr>
<tr>
<td>CA</td>
<td>-5.70%</td>
<td>-5,580</td>
</tr>
<tr>
<td>NY</td>
<td>-10.60%</td>
<td>-8,407</td>
</tr>
</tbody>
</table>

Florida vs. Other Large States

<table>
<thead>
<tr>
<th>State</th>
<th>2010 Admissions</th>
<th>2015 Admissions</th>
<th>Percent Change</th>
<th>Read. Reduced</th>
</tr>
</thead>
<tbody>
<tr>
<td>FL</td>
<td>619,368</td>
<td>588,187</td>
<td>-2.70%</td>
<td>-3,161</td>
</tr>
<tr>
<td>TX</td>
<td>571,147</td>
<td>509,738</td>
<td>-8.70%</td>
<td>-2,905</td>
</tr>
<tr>
<td>CA</td>
<td>574,176</td>
<td>547,558</td>
<td>-5.70%</td>
<td>-5,580</td>
</tr>
<tr>
<td>NY</td>
<td>491,857</td>
<td>462,430</td>
<td>-10.60%</td>
<td>-8,407</td>
</tr>
</tbody>
</table>
Readmissions: A Florida Priority

- Readmissions is not just a hospital issue
- Must have involvement, engagement and commitment from all involved in the patient’s care
- No “magic bullet”

Florida Readmissions Stakeholder Group

- Hospitals
- Nursing homes
- Nursing home medical directors
- Emergency physicians
- Florida Blue

- AHCA
- Community pharmacist
- Case management
- EMS
- Risk management
- Others

State Priorities
Communication

• 3008 Forms are incomplete
• No standardized or interactive “hand-off”
• Patient specific needs are not shared with all caregivers
• Access/Integration with hospital EMR

GOAL: Explore health IT as tool to improve communications at discharge

Medication Management

• Discharge medication reconciliation
• Shared access to EMR
• Adverse Drug Events
• Medication literacy
• “Hand–Off” communication
• Patient and family education
• Cost of medications

Advance Care Planning

• Patient and family engagement on end-of-life care planning
• Provider and staff knowledge
• Patient and family knowledge
• Communication and understanding of patient’s wishes on care transition
How SNF/LTC and Acute Care Can Work Together

- Partner with acute care and providers
- Ensure effective and accurate communication at transition of care

Communication Strategies to Reduce Readmissions

- Ensure standardized clinically pertinent information is complete and available at transition of care
- “Hand-Off” communication
- EMR access across continuum of care
- Multidisciplinary transitional care follow-up

Medication Management Strategies to Reduce Readmissions

- Medication reconciliation and verification
- Assessment of patient and family medication literacy
- Patient and family engagement
- Transitional care coordinators/providers
Advance Care Planning Strategies to Reduce Readmissions

• Community outreach – churches, local organizations
• Healthcare provider education with CME
• Palliative care resources in acute care
• Adoption of “End-of-Life” models

Questions?

Contact

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Leadership Intensive:
Catching, Motivating & Retaining
Your Best Employees

Presented by
Earl L. Suttle, Ph.D.
Leadership Success International, LLC
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Ain’t no mountain high enough
Ain’t no valley low enough
Ain’t no river wide enough

Encourage
Wow! Celebration Stories
Allow team members to share stories
Overview

- How to utilize celebrations to increase work performance
- How to continue growing as leaders
- Increasing your personal power
- How to find the needs of your people
- Understanding people
- 10 Pearls for Motivating and Energizing Your Staff

What do the most talented employees need from the workplace?

“Great Managers and Great Leaders”
It’s a Whole New World

“It’s a whole new world out there, with new playing fields, rules and players. Your choice is to either learn the new game or continue to be the very best player in a game that is no longer being played.”

Larry Wilson

A Definition of Leadership

“The ability to influence the attitudes, thoughts, beliefs and behaviors of others.”

“The winning leaders of today are those who develop other leaders the fastest.”

Great leaders are never satisfied with their current level of performance.
How Should We Grow?
5 Major Leadership Growth Areas

1. People Skills _________________
2. Attitude Skills ________________
3. Communication Skills __________
4. Leadership Skills ______________
5. Personal Growth Skills __________

What is your Personal Growth Plan?

Dr. Earl’s Personal Growth Plan

• Listen one hour per day to CDs in car
• Read something inspirational each morning
• Attend at least one workshop or seminar per month
• Each week speak to a motivational person
• Put something in my journal several times per week
• Attend monthly meeting with my dream circle group

www.earlsuttle.com
@drearlspearls
770-682-6430
Ways to Raise Positivity and Happiness Levels within your organization

Understanding People (How to Have More Personal Power With People)

1. People are _______________
2. People want to ____________
3. People need to be __________
4. People want _______________
“I know God will not give me more than I can handle. I just wish He didn't trust me with so much.”

Mother Teresa

“Great leaders read people before they lead people.”

4 Styles

- **Style 1** Want to talk about it, learn what the team has to say
- **Style 2** Want to hear about it, hear what the experts have to say and be accurate
- **Style 3** Want to get to the bottom line, get it done the right way
- **Style 4** Want to see the big picture, be innovative and have fun with it all
Style 1
Loyalist (Dove)
Get Along People
Strengths:
• Service oriented
• Great listeners
• Team player
• Likes hearing about and expressing feelings
• Trainable
• Slow to change
Value: relationships and cooperation

Style 2
Analyst (Owl)
Get it Right People
Strengths:
• Loves to be right and hates to be wrong
• Likes to take time to get things done
• Likes to work with others who appreciate their abilities
• Wise
• Self control and cautious
• Prefers analysis over emotion
• Slow to change
Value: problem solving, order and quality

Style 3
Pragmatist (Eagle)
Get it Done People
Strengths:
• Loves to take action
• Enjoys the leadership role
• Loves to start projects and complete them
• Direct and to the point
• Loves change
Value: progress and productivity
### Style 4
**Populist (Peacock)**
*Get the Big Picture People*

**Strengths:**
- Loves to respond to intellectual challenges
- Sociable, outgoing
- Optimistic and energetic
- Likes to be the center of things
- Have great ideas

*Value: innovation and creativity*

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"Dr. Earl"'s 10 Pearls for Motivating and Energizing Your Staff"
“To lead people, walk behind them. When the best leader’s work is done, the people say, „Wedid it ourselves‟.”
Chinese Philosopher

True leaders don't create followers. they create more leaders!

You were dynamic!
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Become a Road Scholar TODAY:
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for my Books and CDs
Assessment & Documentation of Pressure Injuries

Presented by
Jeri Lundgren, RN, BSN, PHN, CWS, CWCN, CPT
President
Senior Providers Resource

The New Terminology and the MDS

• National Pressure Ulcer Advisory Panel (NPUAP)
  Updated Terminology and definitions April 2016
• NPUAP Definition August 2016 Press Release:
  “CMS has been in discussions with the NPUAP to incorporate the new terminology. The rollout of the changes will be controlled by these agencies”
• Continue to follow MDS instructions – providers may continue previous definitions to fit MDS terminology or they may adapt the new terminology. Essentially the stages are the same just clarified definitions.

The Definition of Pressure Injuries

• National Pressure Ulcer Advisory Panel (NPUAP)
  Definition April 2016:
  • A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.
The Definition of Medical Device Related Pressure Injury

**National Pressure Ulcer Advisory Panel (NPUAP)**
Definition April 2016:

- This describes the etiology of the injury. Medical device related pressure injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. The injury should be staged using the staging system.

The Definition of Mucosal Membrane Pressure Injury

**National Pressure Ulcer Advisory Panel (NPUAP)**
Definition April 2016:

- Mucosal membrane pressure injury is found on mucous membranes with a history of a medical device in use at the location of the injury. Due to the anatomy of the tissue these injuries cannot be staged.

The Etiology of Pressure Injuries

- Ischemia as a result of sustained deformation of soft tissues will lead to hypoxia, blocking of nutrient supply, and blocking of the removal of waste products. Deprivation of nutrients and change in pH due to waste products will eventually lead to tissue damage (NPUAP, 2014, p.21)
The Etiology of Pressure Injuries

• The duration of time for which tissue cells can endure the ischemia without damage differ for muscle, fat, and skin. Muscle tissues are more susceptible to damage than skin tissues.
• Skin is much stiffer than muscle and fat therefore deforms to a lesser degree in most clinical applications
  • NPUAP, 2014, p.21

Pressure Injuries

The Etiology of Pressure Injuries

• Lower thresholds of pressure and deformation can take a longer period of time before tissue damage occurs
• Higher pressure and deformation strains at higher than 50% will almost immediately (within minutes) lead to tissue damage at the microscopic scale.
• Reperfusion that follows a period of prolonged ischemia may increase the degree of tissue damage because it involves release of harmful oxygen free radicals
  • NPUAP, 2014, p.21
Contributing factors: Microclimate

• An increasing body of evidence suggests that the microclimate between skin and the supporting surface plays a role in the development of Stage 1 and 2 pressure injuries (NPUAP, 2014, p.21)
  • Microclimate is the humidly and temperature
  • Increased humidity and temperature can cause the skin to become weaker and less stiff
  • Excessively dry skin becomes more brittle and liable to break

Pressure Injuries

Contributing Factors: Shear (deformation of tissue)
Contributing Factors: Shear (deformation of tissue)

Moisture Associated Skin Damage (MASD), Secondary to incontinence or perspiration is NOT a pressure injury

Assessment

*GOAL of Assessment:
- To determine the progress of the wound
- To determine the appropriate topical management and overall interventions
Assessment

• Wounds should be assessed/documented at least every 7 days
  - More frequently if:
    • Complications or
    • Per dressing change
  • A clean pressure injury with adequate blood supply & innervation should show evidence of stabilization or some healing within 2-4 weeks.
  • Nurse Notes should reflect progress of wound only.

Assessment

• The weekly wound assessment should be a team effort

• At a minimum the Floor Nurse and the Nurse Manager should be present!!!

Assessment

• When a pressure injury is present, daily monitoring should include:
  - An evaluation of the wound, if no dressing present
  - An evaluation of the status of the dressing, if present
  - The presence of complications
  - Whether pain, if present, is being adequately controlled
Comprehensive Assessment

- **ONE WOUND PER ASSESSMENT**
  - Date
  - Location
  - Stage
  - Size & Depth
  - Wound Base Description
  - Undermining & Tunneling
  - Drainage
  - Wound Edges
  - Odor
  - S/S of Infection
  - Pain

Wound Bed Assessment

- **Describe the tissue in the wound bed using professional terms**
  - Necrotic/eschar
  - Slough
  - Granulation
  - Epithelial

Wound Bed Assessment

- **Necrotic/eschar tissue** – black, brown, or tan tissue
Wound Bed Assessment

- **Slough** – yellow or white tissue that adheres to the wound bed in strings or thick clumps, or is mucinous

![Slough Image]

Wound Bed Assessment

- **Granulation** – pink or beefy red tissue with a shiny, moist, granular appearance

![Granulation Image]

Wound Bed Assessment

- **Epithelial Tissue** – New skin that is light pink and shiny even in darkly pigmented skin

![Epithelial Tissue Image]
Wound Bed Assessment

• Describe the tissue present in the wound bed using percentages:
  - 10% slough tissue, 90% granulation
  - Should equal 100%!!!!!!

Stage 1 Pressure Injury

• Stage 1 Pressure Injury: Non-blanchable erythema of intact skin
  • Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.

Stage 1 Appearance

• Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.
Deep Tissue Injury

- Deep Tissue Pressure Injury (DTP): Persistent non-blanchable deep red, maroon or purple discoloration
  - Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3, or Stage 4). Do not use DTP to describe vascular, traumatic, neuropathic, or dermatologic conditions.

Deep Tissue Injury

- Internal stresses and strains adjacent to bony prominences are substantially higher than those near the surface, and have the potential to cause damage in deep tissues before the superficial tissue is damaged (NPUAP, 2014, p.20)
Evolution of a Deep Tissue Pressure Injury

Stage 2 Pressure Injury

• Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis:
  Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSII), or traumatic wounds (skin tears, burns, abrasions).
Stage 2 Appearance

- Stage 2 pressure ulcers heal by epithelialization (resurfacing), not granulation, therefore the wound base would be described as pink or red verses granulation tissue (impacts MDS 3.0 coding)

Stage 3 Pressure Injury

- Stage 3 Pressure Injury: Full-thickness skin loss:
  
  Full-thickness loss of skin in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage, and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.
Stage 3 Pressure Injury

Stage 4 Pressure Injury

- Stage 4 Pressure Injury: Full-thickness skin and tissue loss

Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Stage 4 Appearance
NPUAP Position Statement (9-27-12)

• Although the presence of visible or palpable cartilage at the base of a pressure ulcer was not included in the stage 4 terminology; it is the opinion of the NPUAP that cartilage serves the same anatomical function as bone. Therefore, pressure ulcers that have exposed cartilage should be classified as a Stage 4.

Unstageable Pressure Injury

• Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss

Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on an ischemic limb or the heel(s) should not be removed.

Unstageable Appearance
Assessment

Pressure Injury Assessment

- Purpose of staging is for consistent communication of depth of tissue destruction
- Once staged, the injury should not be back staged, rather the wound should be described in terms of size, shape, color, drainage, and odor using one of the wound assessment measures (www.npuap.com)

Measuring the Pressure Injury

Measure in centimeters
Use a moistened sterile cotton tip applicator (NS or Sterile water)

Length: longest length from head to toe

Width: Widest width; side-to-side (90-degree angle) to length

Depth: From the visible surface to the deepest area
Assessment

- For tunneling or undermining, use the clock system with resident’s head at 12 o’clock
- When assessing, always use a moistened cotton swab and insert gently

Assessment

- Wound Drainage
  - Amount
  - Color
  - Consistency

Assessment

- Pressure Ulcer Assessment
  - Surrounding Skin
    - Erythema
    - Edema
    - Induration
    - Crepitation
    - Pain
    - Warmth
Pressure Injury Assessment

• Odor if it is present (assess odor only after the dressing is removed and the wound is irrigated)

• Pain – nature, frequency and management

• Signs or symptoms of infection

• Overall Progress (stable, decline, improved or unchanged)

Pressure Injury

• Documentation Tips
  – Ensure care plan has appropriate goals
  – Only list the type of ulcer and location of it on the care plan (i.e., Pressure injury to right trochanter)
  – Once the pressure injury heals, ensure it gets listed on the care plan (i.e., history of pressure injury to right trochanter)
  – Physician diagnosis and prognosis are appropriate

Resources

Available Resources and Web Sites:

– www.wocn.org (Wound, Ostomy & Continence Nurse Society)
– www.ahrq.gov (Agency for Health Care Research and Quality, formally AHCPR)
– www.npuap.org (National Pressure Ulcer Advisory Panel)
– www.woundsource.com (Great source to find wound care products)
References:


Thank You for your Participation

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Sexuality, Intimacy and Quality of Life for Seniors

Joy Siegel, PhD, MBA
Senior Solutions

March 14, 2017
FADONA Annual Convention
Orlando, FL

Number of Americans Age 65 and Older (in millions), Years 1900–2000, and Projected 2010–2050

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Today’s Geriatrics...
According to the U.S. Department of Health and Human Services:

- Age 65 – 74: 19.5% live with fair - poor health
- Age 75+: 25% live with fair – poor health

Presumed Interests of the Geriatric Population

- Recognize that old perceptions of geriatrics no longer apply to aging population
- Can no longer generalize attributes of this group based on age
- Our culture has viewed the elderly as sexually neutered; sex is seen as being for the young
The Need for Affection

Old Age or cognitive impairment does not eliminate the need for:
- Affection
- Intimacy
- Relationships
- Warmth
- Touch

Sexual Rights of Older Adults

- Decisions to be sexually active or not
- Sexual rights protection and promotion should be part of the daily existence of all individuals;
- Sexuality should be recognized as a positive aspect of life
- International organizations have recognized and demanded sexual rights as universal rights based on inherent freedom, dignity and equality of all human beings (WHO, 2000; IPPF, 2006);

QOL Study, UC Ontario (2013)

- Respondent’s measured the following as being most important and enjoyable:
  - Physical Being
  - Psychological Being
  - Spiritual Being
  - Physical Belonging
Quality of Life

- The majority of older adults are engaged in some type of intimate relationship and consider sexuality an important part of life (Lindau, Schumm, Lauman, Levinson, O’Muircheartaigh & Waite 2007).

- “Sexuality has been described as an important component of health and as an integral part of self-expression (Robinson & Molzahn, 2007).”

Importance of Sexual Relationship to Quality of Life by Age and Gender (AARP)

- Recent studies from the New England Journal of Medicine reported that:
  - 70% of the men and 49% of the women reported that sex was important in their lives
  - 74% of married men and 57% of married women > 60 continued to be sexually active
  - 13% of unmarried men and 5% of unmarried women > 60 continued to be sexually active
  - more than 50% aged 57-75 stated that they gave or received oral sex in past month
  - for those ages 75 - 85, 39% of men and 17% of women report having “sex” in the last 12 months

NEJM, 2007
Recent studies from AARP reported that couples over 50:

- 31% couples report having sex (including intercourse) several times a week
- 28% couples report having sex (including intercourse) once a week
- 16% couples report having sex (including intercourse) once a month

AARP, 2011

Recent studies from the University of Manchester:

- 54% of men and 31% of women over the age of 70 reported they were still sexually active
- 33% of these men and women reported having frequent sex (at least twice a month) according to data from the latest wave of the English Longitudinal Study of Ageing (ELSA), 2015

Literature on sexual functioning confirms that sexual desire is important

Sexual desire is significantly associated with reported frequency of sexual touch and sexual intercourse for both men and women

Desire is associated with frequency of masturbation
Sexual Desire

- Sexual desire/interest can be measured by:
  1. Frequency of sexual thoughts
  2. Frequency of enjoyment of sexual activity
  3. Sexual arousal

Sexual Behavior

- Most common behaviors over 80: touching, masturbation, sexual intercourse
- No differences related to sexual orientation
- Preferences may change: less intercourse and more oral sex
- Factors related to sexual maintenance: age, physical health, medications, satisfaction in life, partner availability

Benefits of Sex and Intimacy in the Elderly

- Improves cognitive function
- Improves cardiovascular function
- Source of pleasure
- Enhances sense of self-worth, validation
- Expression of love and affection
- Reduces depression, anxiety, loneliness
- Can enhance creativity and communication
AARP “SEX, ROMANCE, AND RELATIONSHIPS” SURVEY
DATA COLLECTED IN 1999, 2004, AND 2010

- Older adults want health care providers to know that "sex was not just for the young" and to promote an open, accepting environment in which sexual issues could be discussed.
- Of those older adults who are single and in a sexual relationship, only 12% of men and 32% of women reported using protection.
- Which leads to a discussion about RISK & STIs...

Frail Elderly

- With many frail elderly, sexuality is expressed not in the act of sexual intercourse but in the simple pleasure of touch.
- A study of 15 Skilled Nursing Facilities in Texas, with the mean age of 82 years, 81% of men and 75% of women reported sexual desire, but were currently sexually inactive because of lack of opportunity.


The Health Care Provider (HCP)

- How do our perceptions impact our practice as HCPs for the older adult patient?
Nursing Homes and Rehabilitation Centers

- By federal law, LTCF residents and ALF tenants are afforded multiple rights, many of which are relevant to sexuality. These rights include, but are not limited to, the right to privacy, confidentiality, dignity and respect; the right to make independent choices; and the right to choose visitors and meet them in a private location.

(Longtermcare.org)

Sexuality in LTC Communities

- Most still want to be sexually/intimately active
  - Over 60% of elderly residents express a desire for intimacy (Keni, 2008)
- Barriers to intimacy exist
  - Lack of privacy
  - Staff, family attitudes
  - Informed consent issues
  - Lack of a partner

BARRIERS IN THE HEALTH CARE SETTING

- Health Care Provider
  - Discomfort and/or embarrassment
  - Personal beliefs (religious, cultural, etc…)
  - Minimal topic-specific education
  - Lack of time requiring “prioritizing” of health issues that “matter more”
  - Sexuality and sex are more than just genital activities
BARRIERS IN THE HEALTH CARE SETTING

Patient

- Discomfort and/or embarrassment
- Personal beliefs
- Lack of opportunity
- Lack of knowledge
  - Cohort effect
- Community vs. Long Term Care dwelling

Sex and Relationships in Assisted and Long Term Care Communities

Factors to consider:
- Dementia
- Staff attitudes
- Family attitudes
- Partner issues (ie, SDO)

What can we do?

- Assess and examine our own values and feelings and be aware of how these influence the work that we do and environments we create in the "patient - HCP" relationship.
- How do we initiate the discussion? How do we respond when residents ask?
- EDUCATE!
- Incorporate sexual health history into assessment.
Questions to Guide Sexuality Assessment Among Older Adults

- Can you tell me how you express your sexuality?
- What concerns or questions do you have about fulfilling your sexual and intimacy needs?
- Do you have a partner? In what ways has your sexual relationship changed?
- What information or interventions can I provide to help you fulfill your sexuality?

WHAT DO CAN WE DO?

- Safe Sex
  - How would you feel about educating a 70 year old man on proper condom use? Dental dams? HIV testing? Insist on someone with identified STI/D using protection?
- Better sex
  - Are you able/comfortable with giving an 82 year old, woman advice on how to improve her sex life with her current partner? Positions for better orgasm?
  - Types of lubrication, sex toys, positions/methods of sexual expression that accommodate less-abled physical status? Gay and lesbian relationships?

WHAT DO CAN WE DO?

- Regular Group Discussions on Dating, Sexuality, Healthy Relationships
- Provide Private Areas
- Remind Residents That Security Cameras Are Present
- “Do Not Disturb” signs
- Provide social opportunities
WHAT DO CAN WE DO?

- Regular Contact With Family
- Develop Clear Policies on Sexual Expression and Relationships (including issues of consent)
- Provide Staff Training on Geriatric Sexuality

Final Considerations

- Too often, views on sexuality and the elderly are a reflection not of the values of the resident, but rather, the values and attitudes of staff and the facility
- How do we balance caring and controlling; protection and privacy?
- Our places of employment are their homes…

Summary

- Intimacy is a basic need in us all
- Sexuality needs still exist in LTC/ALF/ILF communities
- Approach has to be reasoned, balancing autonomy needs with freedom-from-exploitation rights
- Residents’ values and beliefs about sex and intimacy are more important to them than yours
Wellness Tips & Light Exercise

Presented By:
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President
Senior Providers Resource, LLC

• Improving Medicare Post-Acute Transformation (IMPACT) Act
  • Enacted October 6th 2014
  • Specifies quality measures on which Post-Acute Care (PAC) providers (SNF, IRF & LTCH) are required under the applicable reporting provisions to submit standardized patient assessment data in several domains:
    • Falls
    • Skin Integrity
    • Function

• MDS new section GG “Functional Abilities and Goals”
  • Eating
  • Oral Hygiene
  • Toileting Hygiene
  • Sit to lying
  • Lying to sitting on side of bed
  • Sit to stand
  • Chair/bed-to-chair transfer
  • Toilet transfer
  • Walk 50 feet with two turns
  • Walk 150 feet
  • Wheel 50 feet with two turns
  • Wheel 150 feet
• **Restorative Nursing**
  - Is once a day ROM and propelling/walking once a day 150 feet enough to prevent a decline in Function?

  **NO**

• **Humans are Meant to be Upright & Mobile**

  *Optimal Body Function – Upright for 16 hours/day and 7-8 hours of uninterrupted sleep*

Mobility

• **Mobility** – the ability to efficiently navigate and function in a variety of environments, requires balance, agility and flexibility.
• Root Cause of Falls
  • Falls
    • Strength, Balance and Endurance issue

• The Aging Process Impact on Mobility
  • Sarcopenia
    • The loss of muscle mass with age
    • Each decade the aging adult has 5lbs less muscle and about 15 pounds more fat
    • Resulting in a 20lbs change in physical status and appearance

• The Aging Process Impact on Mobility
  • The primary cause of the loss of muscle mass

DISUSE
• Restorative Nursing
• If you don’t you it, you lose it
• If you rest, you rust

• The Aging Process Impact on Mobility
• Dieting alone without exercise does not have high success rates
  • 25% percent of weight lost during low calorie diets without exercise is actually lost muscle tissue
  • Less muscle leads to slower metabolism
    • Reduced muscle tissue is largely responsible for a 2–5% per-decade decrease in our resting metabolism
    • Slower resting metabolism leads to calories previously used by muscle are routed into fat storage

• What is the best type of exercise??
  • Cardio AND
  • Strength Training
• Benefits of Cardiovascular Exercise
  • Cardiac output
  • Oxygenation of tissue
  • Respiratory function
  • Neuroplasticity – best time for the brain to relearn is during and immediately after exercise

• Cardiovascular Exercise
  • Should be done daily – 10,000 steps a day
  • HIIT – High Intensity Interval Training (1 minute high/1 minute low) for 20 minutes at least 2 days a week
  • 30-60 minute of running, bicycling, rowing, kayaking or swimming at least once a week

• The Aging Process Impact on Mobility
  • All adults should perform regular endurance exercise such as walking and cycling to enhance cardiovascular function. However
  • Aerobic activities do little to prevent gradual deterioration of the musculoskeletal system
  • One study of elite middle-aged runners, the subjects lost about 5lbs of muscle over a 10 year period in spite of extensive aerobic training.
• The Effects of Immobility

The Solution – Strength Training
  • Systemic strength training – use of resistance
    • Adding muscle
    • Losing fat
    • Raising resting metabolic rate
    • Increase daily expenditure
    • Increase bone density
    • Enhance glucose metabolism
    • Increase gastrointestinal transit
    • Lower resting blood pressure and pulse
    • Decrease in depression

• Strength Training Exercise program:
  • Studies have shown that muscle mass can be increased at essentially any age through systemic strength training even if they have never done strength training before

• Frequency of Exercise
  • Strength exercises may be productively performed two to three days per week – Allow 48 hours of rest in-between sessions
  • Research has shown that 2 days a week of strength training is beneficial and just as effective as 3 days.
• Goals of Exercise

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<th>Fitness</th>
<th>Performance</th>
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<tbody>
<tr>
<td>5 Days a week</td>
<td>3-4 Days a week</td>
<td>7 Days a week</td>
</tr>
<tr>
<td>Moderate Intensity</td>
<td>Vigorous/High Intensity</td>
<td>Very Hard Intensity</td>
</tr>
<tr>
<td>30 minutes a Day</td>
<td>30-45 Minutes per Day</td>
<td>2 Hours per Day</td>
</tr>
<tr>
<td>Walk 6-12 miles/week</td>
<td>Jog 10 miles/week</td>
<td>Run 100 miles/Week</td>
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Individual Goal Setting
• Needed for Starting Point & to Measure Progress
  • Short Physical Performance Battery (SPPB)
  • Anthropometric Measurements
  • Muscle Quality Index
  • Hand Grip Strength
  • Steps per Day
  • Resting Heart Rate
  • Resting Blood Pressure
  • Waist to Hip Ratio

• Equipment
  • Your own body weight
  • Dumbbells and/or resistance bands
  • Ankle weights
  • Sturdy Chair
  • Steps, counter tops, walls
• Exercise should be done in the standing position as much as possible
• Near a wall or have a chair handy if slight balance issues
• Sitting position if unable to bear weight safely

• Develop Exercises that call for exercise for each of the major muscle groups
  • Quadriceps
  • Hamstrings
  • Pectoralis Major
  • Latissimus Dorsi
  • Deltoids
  • Biceps
  • Triceps
  • Erector Spinae
  • Rectus Abdominus
  • Neck
  • Flexors/Extensors

• Strength Training
  • Proper warm-up before all exercise is important for at least 5 minutes
    • Simple walking or marching – can be done while sitting for standing balance issues
    • Large body movements – Dynamic stretching
    • When warming up no static stretching
• Training Speed
  • Performed movement slowly
  • Using strength not momentum
  • Pace should be 6 seconds total
    • 2 second to lift and
    • 4 seconds to lower the weight

• Breathing
  • DO NOT HOLD BREATH EVER!!!!
  • Inhale before starting a strengthening exercise and exhale upon exertion
  • Moving against gravity is the exertion phase – away from the floor

• Training Range
  • Full-range exercise movements are necessary for building full-range muscle strength.
  • Each exercise should be performed through the complete range of joint movement
  • However do not go to the point of locking the joint
  • If any part of the exercise causes discomfort, the movement range should be abbreviated accordingly.
  • Promote joint function, safety and stability. Do not overextend or overflex the limbs. Perform all movements in the most secure, stable and functional positions possible for the individual
• Proper Cool Down - Stretching
  • Tips:
    • Hold stretches for 15-30 seconds or more
    • Go to the point you feel the muscles stretching
    • Do not go past that point where it starts to hurt
    • Always ease into a stretch gently

• Stop Exercise if any of the following warning signals
  • Light headedness, dizziness
  • Breathlessness, shortness of breath
  • Higher than normal levels of joint, muscle, or skeletal pain or discomfort
  • General weakness, extreme fatigue
  • Anginal pain which may occur in the chest, neck, jaw, back or limbs
  • Excessive sweating, cold sweats, clamminess
  • Heart palpitations, irregular pulse
  • The resident stops for any reason

• Exercises for specific conditions/concerns
  • Alzheimer’s Disease
    • Amyloid plaques in the brain
    • Interventions to decrease amyloid plaques
    • Adequate sleep
    • Exercise

Guest Column in McKnights:
http://www.mcknights.com/guest-columns/lifestyle-and-the-aging-brain/article/417260/?DCMP=EMC-MCK_Daily&spMailingID=11530562&spUserID=ODE2NDE0MDMwNDES1&spJobID=560074336&spReportId=NTYwMDc0MDc0MzM290
• Exercises for specific conditions/concerns
  • Parkinson Disease
    • Mobility – the ability to efficiently navigate and function in a variety of environments, requires balance, agility and flexibility all of which are affected by Parkinson Disease.
    • Rigidity, bradykinesia, freezing, poor sensory integration, inflexible program selection and impaired cognitive processing limit mobility in people with Parkinson Disease.

  • Parkinson Disease/Balance
    • Obstacle Courses
    • Ladder drills
    • Kayaking
    • Lunges & Kicks
    • BIG & LOUD movements
    • Quick Boxing Movement

• Exercises for specific conditions/concerns
  • Parkinson Disease
    • Tai Chi
• Exercises for specific conditions/concerns
  • Cognitive Impairment
    • Inability to simultaneously carry out a cognitive task and a balance or walking task has been found to be a predictor of falls in elderly people.
    • Agility program could progress task difficulty by adding cognitive or motor tasks that teach residents to maintain postural stability during performance of secondary tasks
      • Exercise Level 1: Have no dual tasks
      • Exercise level 2: has a motor task (bouncing a ball) added to the basic exercise such as an agility course
      • Exercise level 3: has a cognitive task (performing math or memory problems) added to the same basic exercise
    • The progression of adding secondary tasks to gait and balance tasks serves as a training device as well as a tool to help residents understand the relationship between safe mobility and secondary tasks in everyday life

  • Exercises for specific conditions/concerns
  • Cognitive Task and Balance Task Example - One Foot and One Toe Behind
    • Stand behind your chair and hold on to it
    • Place your right foot flat on the ground and bring your left foot behind your right but as you set it down only allow the big toe to touch the ground
    • Most of your weight should be on your right foot
    • Balance there for 30 seconds and try to use your chair as little as possible
    • To make it harder, you can move your head up and down
    • Look up at the ceiling and then slowly move you head down and look at the floor and repeat for 30 seconds (do not strain to far back just enough to see the ceiling or too far forward just enough to see the floor)

  • Exercises for specific conditions/concerns
  • Cognitive Task and Walking Task Example
    • Basic – Walk forward taking normal-length steps, but bring your knees up higher than usual with every step. The higher you raise your knees up the more stable you will be
    • Intermediate – Walk forward again, but this time, only raise your left knee as you walk. Your right leg should just take a normal-looking step forward without exaggerated knee lift. Try again with the opposite leg
    • Advanced – This time you will walk forward and take a high knee with every third step – Quite tricky!!
Lets Get Our Bodies Moving!!
&
Our Brains Working!!

Thanks for your participation!!!

Jeri Lundgren, RN, BSN, PHN, CWS, CWCN, CPT
President
Senior Providers Resource, LLC
jeri@seniorprovidersresource.com
Cell: 612-805-9703
Reform of Requirements for Long Term Care Facilities and the New LTC Survey Process

Presented by:
Kimberly Smoak, MSH, QIDP
Chief of Field Operations
Health Quality Assurance
Agency for Health Care Administration
March 2017

Objectives

- Provide an overview of the revised survey process.
- Discuss timelines for implementation of the revised survey process.
- Discuss the Phase I implementation of the federal long term care requirements.

New Survey Process
Proposed New Process

- Will be computer based
- Two Parts
  - Sample Selection
  - Investigation

Sample Size

- Based on facility census
- Sample Split:
  - 70% offsite using MDS algorithm
  - 30% selected onsite

MDS Algorithm Indicators

- 70% of the sample
  - MDS indicators covering high risk areas
  - Some indicators are paired with certain conditions
  - Sample based on prevalence rate
  - Facility Matrix Report
Remaining 30% Sample Section

- Selected onsite by surveyors
- High risk, vulnerable residents
- New admissions in last 30 days
- Active complaints
- Other residents with identified concerns

Sample Selection Process

- Day 1 = Interview and observe potential sample residents, review record/matrix, as needed
  - Cover QOL and QOC categories
  - Ask questions as you would like
  - Determine if concern warrants investigation
- Day 1/Day 2 = Finalize sample

Investigative Process

- Remainder of survey = investigating residents and tasks
- Facility Tasks:
  - Required/Concern specific tasks
  - Resident Council Meeting
  - New ABN Beneficiary Notice Survey Process
Implementation Timeline

- November 2017
  - Type of Change
    - F Tag numbering Interpretive Guidance (IG) Implement new survey process
    - New F Tag numbers, IG Changes and Begin surveying with the new survey process

Provider and Industry Communication

- Various modes of communication
- Overview of new process
- Encouraging providers to be prepared for the survey process
- Feedback

Centers for Medicare and Medicaid Services Reform Requirements for Long Term Care Facilities
Background

• The federal requirements for Long-Term Care (LTC) Facilities are the health and safety standards that LTC facilities must meet in order to participate in the Medicare and Medicaid Programs.
• The current requirements are found at 42 CFR 483, Subpart B.
• These requirements have not been comprehensively updated since 1991.

LTC Regulation Revisions

• Finalized provisions reflect
  – Advances in the theory
  – Practice of service delivery
  – Safety
  – Implement sections of the Affordable Care Act (ACA)

Improvement

• Key Areas
  – Quality of Life
  – Health Care
  – Services
  – Patient Safety
Themes of the Rule

- Person Centered
- Quality
- Facility Assessment & Competency based approach
- Competency of Staff
- Resident Rights
- Infection Control

Themes of the Rule

- Strengthened Transfer
- Discharge Protections
- Alignment with current HHS initiatives
- Comprehensive review and modernization
- Implementation of legislation

Implementation

- Effective Dates:
  - Phase 1: November 28, 2016
  - Phase 2: November 28, 2017
  - Phase 3: November 28, 2019
Phase I Overview

- Effective 11/28/2016
- Full implementation of Basis and Scope and Definitions
- Regulatory Groupings become Regulatory Sections, Expand from 15-21
- Full Implementation of 5 Regulatory Sections
- Minor Modifications to 15 other Regulatory Sections
- 20 of 21 Regulatory Sections have all or some regulations implemented in Phase 1

Regulatory Sections Fully Implemented

- Resident Assessments (483.20)
- Quality of Life (483.24)
- Physician Services (483.30)
- Laboratory, radiology, and other diagnostic services (483.50)
- Specialized Rehabilitation (483.65)

New Regulatory Sections

- Freedom from Abuse, Neglect, and Exploitation (483.12)
- Comprehensive Person-Centered Care Planning (483.21)
- Behavioral Health Services (483.40)
- Laboratory, radiology, and Other Diagnostic Service (483.50)
- Quality Assurance and Performance Improvement (483.75)
- Training Requirements (483.95)
- Compliance and Ethics Program (483.85)
What’s New

483.5 Definitions

• Abuse
• Adverse Event
• Exploitation
• Misappropriation of resident property
• Mistreatment
• Neglect
• Person Centered Care
• Resident Representative
• Sexual abuse
• Willful

483.10 Resident Rights

• Retaining all existing residents’ rights
• Updating the language and organization of the resident rights provisions
• Clarifying regulations where necessary
• Updating provisions to include advances
483.10 Resident Rights-continued

• F151
  – Resident has the right to exercise rights without interference.
• F152
  – Competent residents have the right to designate a resident representative.
  – Resident representative exercises their decision making.
  – Resident retains right to make decision outside representatives authority.
  – Report concerns about a resident representative as required by State law.

483.10 Resident Rights-continued

• F153
  – Personal and medical records are provided as requested by the individual.
  – Records are provided in a manner the resident can understand.
  – A reasonable, cost based fee.

483.10 Resident Rights-continued

• F155
  – Moves to quality of life.
  – Resident also has the right to request and/or discontinue treatment or to participate in experimental research.
  – Advances-Directives-provided by facility or an outside contractor.
  – If adult individual was incapacitated at the time of admission, the information provided to the resident representative and then to the resident.
483.10 Resident Rights-continued

- **F156**
  - Residents are aware of who and how to contact other primary care professionals, received notification such as expanded resources, home and community based service programs, able to request information about returning to the community.
  - Made aware of changes to charges for services not covered under Medicare/Medicaid.
  - Refunds were made to the resident, resident representative or estate.
  - Admission contract did not conflict with requirements of the regulations.

- **F158**
  - Resident is informed of charges in advance.

- **F159**
  - There are now differing dollar amounts for Medicaid residents with other residents.

- **F160**
  - Conveyance of funds for discharge or evicted residents.

- **F162**
  - Residents are not charged for food and nutrition or hospice services.
  - Items and services that may be charged to resident if not required to achieve residents' goals.
  - Facility has considered resident food and cultural preferences for meals.
  - Resident was informed of any item or service when there is a charge.
### 483.10 Resident Rights-continued

- **F163**
  - Verify the physician is licensed to practice in the state.
  - Determine if resident was informed that their physician is unable or unwilling to meet the requirement, and the facility is seeking an alternate physician.
  - Ensure residents choice of physician.
- **F164**
  - Ensure medical records are kept confidential.

### 483.10 Resident Rights-continued

- **F166**
  - Determine residents have information on how to file a grievance or complaint.
  - Ensure that there is a grievance policy.
- **F167**
  - Ensure the most recent survey results during the past 3 preceding years, as well as certification and complaint investigations are posted and readily accessible.
  - Ensure that identifying information about complainants or residents are not available.

### 483.10 Resident Rights-continued

- **F168**
  - Ensure facility staff did not prohibit or discourage a resident from communicating with external entities.
- **F169**
  - Facility can not require a resident to perform services for the facility.
### 483.10 Resident Rights-continued

<table>
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<tr>
<th>F170</th>
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<tbody>
<tr>
<td>Privacy of electronic communications is provided.</td>
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<tr>
<td>Resident is able to receive mail/packages from other than the postal services.</td>
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<tr>
<th>F171</th>
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<tr>
<td>Facility supported residents right to communication, including the ability to send mail.</td>
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<th>F172</th>
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<tbody>
<tr>
<td>Right to receive visitors at the time of their choosing.</td>
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<tr>
<td>Facility policy includes visitation rights.</td>
</tr>
<tr>
<td>Resident and visitors informed of policy.</td>
</tr>
<tr>
<td>Facility staff do not restrict, limit or deny visitation privileges.</td>
</tr>
<tr>
<td>Privileges are consistent with residents preferences.</td>
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<tr>
<th>F174</th>
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<tbody>
<tr>
<td>Expanded access to cell phone use, TTY and TTD services.</td>
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<th>F175</th>
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<tr>
<td>Right to choose a roommate.</td>
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<th>F176</th>
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<tr>
<td>How the facility determined self-administration was clinically appropriate.</td>
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<th>F177</th>
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<tr>
<td>Facility may not perform a transfer solely for convenience of staff.</td>
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</table>
483.10 Resident Rights-continued

- F240
  - Every resident is treated with respect and dignity.
  - Policies for practice such as transfer, discharge and equal access to services regardless of payment source.
- F242
  - Resident right to choose has been expanded.
- F243
  - Notify residents and family of upcoming meetings in a timely manner.

483.10 Resident Rights-continued

- F244
  - Facility provided response and the rationale for their response.
- F247
  - Notice was provided in writing and included the reason for change.
- F252
  - Environment maximizes residents independence.
  - Responsibility for the protection of the residents property.
- F280
  - Residents participation in his/her person-centered care plan.

483.12 Freedom from Abuse, Neglect and Exploitation

- Strengthens existing protections, in addition to review of policies and procedures.
- Adds language related to resident “right to be free from neglect” and “exploitation.”
- Requires facilities to investigate and report all allegations of abuse conduct.
- Individuals who had a disciplinary action taken against their professional license by a state licensure body can not be hired by facilities.
483.12 Freedom from Abuse, Neglect and Exploitation-continued

- F223
  - Continue to review citations relate to abuse, corporal punishment, and involuntary seclusion at F223.
  - New definitions for "abuse" and "sexual abuse."
- F224
  - Will be cited if the facility failed to ensure residents are free from neglect, misappropriation and exploitation.

483.12 Freedom from Abuse, Neglect and Exploitation-continued

- F225
  - Facility requirement is not limited to only facility employees but also individuals the facility engages.
  - Alleged violations must be reported immediately.
  - Immediate reporting also includes to the State APS agency.

483.12 Freedom from Abuse, Neglect and Exploitation-continued

- F226
  - Will continued to be cited when facility has failed to develop and implement policies and procedures to prohibit abuse, neglect, misappropriation of resident property and exploitation.
483.12 Freedom from Abuse, Neglect and Exploitation-continued

- F221
  - Physical restraints
- F222
  - Chemical restraints
  - When restraints are used the facility must:
    - Use least restrictive alternative for the least amount of time, and
    - Document ongoing re-evaluation of the need for restraints.

483.15 Admission, Transfer and Discharge Rights

- Transfer or discharge to be documented in medical record, including specific information which should be exchanged with receiving provider or facility when a resident is transferred.

483.15 Admission, Transfer and Discharge Rights-Continued

- F201
  - Requires additional documentation- if facility has transferred or discharge resident while an appeal is pending.
483.15 Admission, Transfer and Discharge Rights-Continued

• F203
  – Requires facility to send a copy of the transfer or discharge notice to the ombudsman.
  – Requires facility to provide resident and/or representative with additional information in the notice regarding the process for appealing transfer/discharge.
  – Requires facility to update recipients of transfer/discharge notice of any changes to the notice as soon as possible, if the changes occur prior to the transfer/discharge.

483.15 Admission, Transfer and Discharge Rights-Continued

• F204
  – New regulatory language at F204 adds that the orientation facilities provided to the residents regarding transfer or discharge must be in a manner they understand.

483.15 Admission, Transfer and Discharge Rights-Continued

• F205
  – Changes “readmission” to “return.”
  – New language requires the facility to provide written information to residents or representative about payment needed to hold a beds if the individual state requires payments to hold beds.
483.15 Admission, Transfer and Discharge Rights-Continued

- F206
  - If facility decides a resident cannot return to facility, the facility would then discharge residents.
  - “Readmission to a composite distinct part” provision is not new, but has been added to F206 if concerns are identified.
- F207
  - “Room changes in a composite distinct part” is not new, but has been added to F207 since it may indicate unequal treatment of residents.

483.15 Admission, Transfer and Discharge Rights-Continued

- F208
  - Ensure facility has not required resident to waive potential facility liability in the event of loss of property.
  - Facility to disclose any specific characteristics or limitations of facility.

483.20 Resident Assessment

- Clarification to what constitutes appropriate coordination of a resident assessment with Preadmission Screening and Resident Review (PASARR) program under Medicaid.
483.20 Resident Assessment-Continued

- F272
  - Residents strengths, goals, life history and preferences in his/her comprehensive assessment.
  - Evidence of resident and direct care staff participation.

483.20 Resident Assessment-Continued

- F285
  - Coordination Includes:
    - Incorporating recommendations from PASARR level II determination and evaluation report.
    - Significant change in status- referring all level II residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review.

483.20 Resident Assessment-Continued

- F286
  - Updated language as "and use the results of the assessments to develop, review and revise the residents comprehensive care plan" was not previously included in the SOM.
483.21 Comprehensive Person-Centered Care Planning

- Addition of nurse aide and member of the food and nutrition services staff to required members of interdisciplinary team that develops care plan.
- Requires facilities to develop and implement a discharge planning process.
- Implementing discharge planning requirements mandated by The Improving Medicare Post-Acute Care Transformation Act of 2014.

483.21 Comprehensive Person-Centered Care Planning-Continued

- F279
  - The Care Plan Must:
    - Be centered on resident's needs and include measureable objectives and timeframes.
    - Include specialized services facility will provide as a result of the PASARR.
    - Have a documented rationale in medical record if they disagree with the PASARR findings.
    - Include goals for admission and discharge preferences.

483.21 Comprehensive Person-Centered Care Planning

- F280
  - Facility involved a nurse aide responsible for resident and member of food and nutrition service, along with attending physician and a registered nurse.
  - Any other professionals needed in development of the care plan as based on residents care needs.
  - Facility has reviewed and revised care plan after each assessment for both comprehensive and quarterly assessments.
483.21 Comprehensive Person-Centered Care Planning

• F281
  – Services outlined in comprehensive care plan must meet professional standards of quality.

• F283
  – When discharge is anticipated for a resident the facility must have a discharge summary.

483.21 Comprehensive Person-Centered Care Planning

• F284
  – Discharge Planning
    • Begins on admission.
    • Included in care plan.
    • Must involve resident and/or representative, and be developed by the interdisciplinary team.
    • Document from the local contact agency (LCA) if resident wishes to be discharged to community.
    • Facilities must assist the resident/representative wishing to be discharged.

483.24 Quality of Life

• No new requirements
• “Highest Practicable Well-Being” language in this section
• Each resident to receive and facility to provide the necessary care and services to attain or maintain the highest practicable well-being, consistent with the resident’s comprehensive assessment and plan of care.
483.24 Quality of Life-Continued

• F309
  – Resident receives dialysis according to care plan.
  – Each staff provides dialysis care consistent with current professional standards of practice.

• F310
  – Now under Quality of Life.
  – Adds oral care and expanded to include dining.
• F311 and F312
  – Also moved to Quality of Life.

483.25 Quality of Care

• Added special care issues, many of which were cited under F309, if there were care issues.
• Specific areas such as, restraints, pain management, bowel incontinence, and dialysis services.
• Comprehensive assessment of a resident.
483.25 Quality of Care-Continued

- F313 and F314
  - No significant changes.
- F315
  - Residents who are continent receive services to maintain continence;
  - Residents with or admitted with a catheter are assessed for removal as soon as possible; and
  - Residents with fecal incontinence receive appropriate treatment and services to restore as much bowel function as possible.

483.25 Quality of Care-Continued

- F323
  - Facility must attempt to use appropriate alternatives prior to installing a side or bed rail and ensure correct installation, use and maintenance including, but not limited to:
    - Assessing the resident for risk of entrapment.
    - Review risks and benefits of bedrails.
    - Ensure bed demission's are appropriate.

483.25 Quality of Care-Continued

- F328
  - Expanded regulatory language in the areas of:
    - Foot care
    - Colostomy, urostomy, or ileostomy care
    - Parental fluids
    - Respiratory care
    - Prostheses
483.30 Physician Services

- Attending physicians to delegate dietary orders to qualified dietitians or other clinically qualified nutritional professionals and therapy orders to therapists.

483.30 Physician Services-Continued

- F385
  - Orders to meet the immediate care and needs of the resident.
- F390
  - If dietitian, other clinically qualified nutrition professional, or a qualified therapist has been delegated the task of writing orders:
    - They are able to do in accordance with State law.
    - The written order was delegated by physician.
    - They are acting under the supervision of a physician.

483.35 Nursing Services

- Addition of competency requirement for determining the sufficiency of nursing staff, based on a facility assessment, which includes but is not limited to the number of residents, resident acuity, range of diagnoses, and the content of individual care plans.
483.35 Nursing Services-Continued

- F353
  - Sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to each resident.
  - Sufficient number of nurse aides, along with other nursing personnel, on a 24 hour basis to provide nursing care to all residents in accordance with resident's care plans.

483.35 Nursing Services-Continued

- F497
  - In-service training
    - Include dementia management and abuse.
    - Prevention in regular in-service education for all nurse aides.

483.40 Behavioral Health Services

- Comprehensive assessment and medically related social services.
- New requirement, incorporates highest practicable well-being, specialized rehabilitation, and medical social services.
**483.40 Behavioral Health Services-Continued**

- **F319**
  - Review of residents who display and/or diagnosed with mental disorder or psychosocial adjustment difficulty.
  - Facility must correct resident's assessed problem or assist resident in attaining their highest practicable mental/psychosocial well-being.
- **F320**
  - Residents who do not have a diagnosis of mental disorder or psychosocial adjustment difficulty to ensure they do not have an avoidable decrease in social interaction since admission to the facility.

**483.45 Pharmacy Services**

- Pharmacist must review a resident's medical chart during each monthly drug regimen review.
- Revision of existing requirements.
- Define "psychotropic drug" as any drug that affects brain activities associated with mental processes and behavior.

**483.45 Pharmacy Services-Continued**

- **F428**
  - Requires new process for medication regimen review (MRR) and requires facilities to develop and maintain policies and procedures to address all aspects of the MRR.
483.50 Laboratory, radiology and other diagnostic services

- A physician assistant, nurse practitioner, or clinical nurse specialist may order laboratory, radiology, and other diagnostic services for a resident in accordance with state law, including scope of practice laws.

483.50 Laboratory, radiology and other diagnostic services-Continued

- F504
  - Facility provides or obtains laboratory services.

- F505
  - Facility staff promptly notifies the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist.

483.50 Laboratory, radiology and other diagnostic services-Continued

- F510
  - Facility provides or obtains radiology and other diagnostic services.

- F511
  - Facility staff promptly notifies the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist.
483.55 Dental Services

- F411
  - Assistance is not only provided when deemed necessary, but also when requested by resident.
  - Transportation is provided.
- F412
  - Facility submits an application for reimbursement of dental services under the State plan, if the resident is eligible and wish to participate.

483.60 Food and Nutrition Services

- Facilities to provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.

483.60 Food and Nutrition Services-Continued

- Facilities to employ sufficient staff, including designation of a director of food and nutrition service, with appropriate competencies and skills sets to carry our the functions of dietary services.
483.60 Food and Nutrition Services—Continued

• F360
  – Resident preferences

• F361
  – Demonstration of staff competencies and skills in food service.
  – Explicit regulatory requirement to meet State requirements for food service or dietary managers.

• F362
  – Change in language from "competent" to "safely and effectively."
  – Verify who from the Food and Nutrition Services staff is participating on the IDT.

• F363
  – Menu must reflect the religious, cultural, an ethnic needs of the resident population and input from residents and resident groups.

• F364
  – Drinks from now meet these requirements.
  – Expanded to include meeting hydration needs and preferences regarding fluids.

• F366
  – Accommodating resident allergies, intolerances and preferences.
483.60 Food and Nutrition Services-Continued

• F368
  – Meals meeting resident needs, preferences, requests, care plan are now explicitly required.
  – Alternative meals/snacks provided.
• F369
  – Appropriate assistance provided to residents to use assistive devices when consuming meals and snacks.

483.60 Food and Nutrition Services-Continued

• F371
  – Food from local procedures meeting applicable state and local laws and regulations.
  – Produce from facility gardens are grown and handled safely.
  – Residents are able to have foods from outside the facility.

483.65 Specialized rehabilitative services

• Addition of respiratory services to those services identified as specialized rehabilitative services.
483.70 Administration

- F251
  - Social workers- bachelors degree can now include gerontology.
- F492
  - Regulatory language provides additional protection against discrimination and for protection of health information.

483.70 Administration-Continued

- F493
  - Administrator reports to and accountable to the governing body.
- F514
  - Medical records new language included.
- F519
  - Transfer of resident to hospital by another practitioner.
  - Exchange of information.

483.70 Administration-Continued

- F523
  - Written notification of an impending closure must be submitted by the facility to the following:
    - State Survey Agency
    - State LTC Ombudsman
    - Residents in the facility
    - Legal representative of the residents
483.70 Administration-Continued

• F526 (new tag for hospice services)
  • Nursing homes must develop and implement a written agreement between the nursing home and Medicare certified hospice, if the nursing home chooses to allow a Medicare certified hospice to provide hospice care and services in the nursing home.

483.70 Administration-Continued

• F527 (new tag for submitting staffing data)
  – Facilities must now submit electronically to CMS complete and accurate staffing information.

483.75 Quality Assurance and Performance Improvement

• Facilities will develop, implement and maintain effective comprehensive, data driven QAPI program that focuses on systems of care, outcomes of care and quality of life.
### 483.75 Quality Assurance and Performance Improvement-Continued

- **F520**
  - Clarifies committee members.
  - Facility must report to their governing body or designated persons regarding activities.
  - Must meet quarterly.

### 483.80 Infection Control

- **F441**
  - Develop and implemented an infection control program:
    - When and to whom to report infections.
    - What types of transmission-based precautions will be used and when to use them.
    - Infection control incidents and facility corrective actions.

### 483.90 Physical Environment

- Facilities that are constructed, re-constructed, or newly certified after the effective date of this regulation to accommodate no more than two residents in a bedroom and to have a bathroom equipped with a least a commode and sink in each room.
483.90 Physical Environment-Continued

• F461
  – Follow manufactures recommendations and specifications for installing and maintain bed rails, and conduct regular inspection.

483.95 Training Requirements

• New section to subpart B
  • Facilities must develop, implement, and maintain an effective training program for all new and existing staff
  • Other individuals must be trained, consistent with their specific roles
    – Contract staff
    – Volunteers

483.95 Training Requirements-Continued

• F495
  – Addresses required in-service training for nurse aides.
  – Includes dementia management training and resident abuse prevention training.
Contact Information

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ADVANCE DIRECTIVES AND THE IMPACT OF THE RESIDENT REPRESENTATIVE ON THE ROLE OF SUBSTITUTE DECISIONMAKER

FADONA 30TH ANNIVERSARY CONFERENCE

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PRIMER ON ADVANCE DIRECTIVES:
- State law determines
- Federal regulations address
Several types
- Living Will
- Health Care Surrogate Designation
- Durable Power of Attorney
- Yellow DNRO

May be written or oral
- Written should be signed with 2 witnesses
- Surrogate can make decisions, access records, and apply for funding with no more specific authority
- Oral must be witnessed and should be reduced to writing as soon as practicable

- Florida Statute 765

DPOA must take effect immediately upon signing if signed on or after October 1, 2011
- Resident may override if competent to make medical decisions
- Resident may revoke
- Even if resident is allowing agent to make decisions, should be given information and allowed to participate
Emergency Medical Technicians uniform do not resuscitate order

- Physician can write do not resuscitate order - yellow form not necessary for all purposes
- It is necessary for EMT's to honor it
- Details found in Section 401.45, Florida Statutes
- Can be a copy - see Rule 64J-2.018(1)(a)
- Copy should travel with the resident if they leave the facility

FEDERAL REGULATIONS - NOVEMBER 2016

- Emphasis on Person-centered care which is defined as:
- “...to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives”

How does this impact providers?

- More emphasis on issues such as resident’s rights
- More likely to find related deficiencies such as in administration
Some other tags:

- F 151 “the facility must ensure that the resident can exercise [their] rights without interference, coercion, discrimination or reprisal from the facility.” Furthermore the resident has the right to be supported in the exercise of their rights
- F 152 the right to designate a resident representative
- F 153 the right to access personal and medical records
- F 490 administration

Federal Requirements

Definitions:

- Advance Care Planning basically when you use an advance directive
- Advance Directive a written instrument recognized under state law relating to provision of health care to an incapacitated person (acknowledges some states have oral as well)
- CPR any medical intervention to restore circulatory or respiratory function
- Health care decision-making consent, refusal to consent or withdrawal of consent

- Applies state law
- In Florida the incapacity to make medical decisions is not determinative of the inability to make other decisions
- May be intermittent
- May change and facility should be aware of the need to reassess
Life sustaining treatment
- Based on reasonable medical judgment
- Sustains a resident’s life and without which the resident will die
- Medications and mechanical or manual interventions
- Kidney dialysis and nutrition and hydration specifically mentioned
- Does not include medications or treatments to alleviate pain or discomfort

Policies and Procedures
Federal law requires that you have policies and procedures on Advance Directives:
- Determine on admission whether the resident has an advance directive and if not does he want one
- Cannot require one
- System for periodically assessing the resident for capacity
- Method to invoke substitute decision-maker when resident incapacitated
- Method to clarify medical issues and present relevant information to resident or substitute decision-maker
- Review, identify and clarify resident’s condition as part of the comprehensive assessment and care planning process
- Make adjustments to documents as identified in this process
Delineate residents' wishes and if they change.
Identify times when decision-making needs to be reviewed such as change in condition.
Reviewing the resident’s condition and choices and modifying as appropriate.

Establish methods of documentation and communication with staff as to residents' choices.
Identify situations where the facility and/or the resident's physician do not believe they can supply care in accordance with the resident’s wishes or advance directives based on conscience.

Residents must be educated on their rights.
- At admission:
  - Written information re rights to make treatment decisions
  - Written information re resident’s right to advance directives
  - Information on legally available advance directives
  - Facility’s policy re Advance Directives
Document and ensure safety of Advance Directives

- System of storing and retrieving
- System of locating at time of need
- System of sending advance directive to hospital or elsewhere resident may receive medical care

After admission it is an ongoing process:
- Integral part of the comprehensive care planning process
- Must reassess resident’s goals and wishes as condition changes
- Don’t overlook mental condition
- Reevaluate on a routine basis
- Also when condition changes

CPR:
- Cannot have a facility-wide no CPR policy
- American Heart Association has guidelines which are amended regularly - make sure you have the latest
- Must have staff trained in CPR
Must initiate unless
- Valid DNRO in place
- OBVIOUS signs of clinical death
- Rigor mortis
- Dependent lividity
- Decapitation
- Transection
- Decomposition

**Resident representative**
- New right created in the 1916 changes to ROP
- May create confusion
- Scope of powers determined by resident
- Need policy and procedure
- Need standardized method of documenting

**DEFINITION:**
- An individual chosen by the resident to act on behalf of the resident in order to support the resident in decision making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications
In contrast, the CMS definition of a LEGAL REPRESENTATIVE is a person designated and authorized by an advance directive or State law to make a treatment decision for another person in the event the other person becomes unable to make necessary health care decisions.

A PERSON CAN BE BOTH

Right:
- To designate a resident representative
- To establish the parameters of what that representative can do
- To revoke that designation
- All in accordance with applicable state law
The Facility must:

- Treat the decisions of the resident rep as the decisions of the resident
- Limit the resident rep’s authority to that permitted by the resident
- Report concerns if think resident rep not acting in the best interests of the resident

- May be court-appointed
- Must consider resident’s preferences and wishes
- Resident must be afforded right to participate in care planning to the extent practicable

Case Scenario:

- A resident has identified her daughter as her proxy to make medical decisions. Upon admission to the center, she designates her neighbor to receive notifications and to access her medical and financial records.

- The daughter and the neighbor are at odds. The daughter thinks the neighbor has been trying to get her mother to rewrite her will to leave a chink of her substantial assets to her
DISCUSSION POINTS

Can the daughter using her proxy designation to keep the facility from the giving records to the neighbor?
What if the resident is confused?
What if the resident is so confused that she doesn’t understand the rights she gave the resident rep?

- What if the daughter says that the notifications the facility is sending out include too much medical information?
- What complications arise if a staff member overhears the neighbor talking to the resident about going to an attorney together?
Send Every Patient Home Safe and Happy
How to turn discharged patients into repeat customers

Objectives
- Learn about Medication Management in Care Transitions
- Understand the benefits of a successful discharge plan
- Learn how to prevent readmissions
- Learn how to enhance reputation and customer satisfaction
- Understand Customer Loyalty

Turn discharged patients into repeat customers
Adherence to Medication after Hospital Discharge in the Elderly

- 2013 Research Article, International Journal of Family Medicine
- Patients over the age of 65 (average age 76)
- 24-48 hours after discharge from hospital
- Compare discharge instructions with medications at home

Readmissions due to Medication

- 33%-69% of medication-related hospital admissions in United States
- Cost of $100 billion per year

Adherence Rate to RX post discharge

- Adhered 7%
- Did not adhere 93%
Errors in taking RX


Discharges to community

Weekly Discharges

- 10 Total avg. per week
- 5.1 to home
- 2.9 to assisted living

Annual Discharges by Location

- Home 50%
- Skilled Nursing 8%
- Assisted Living 29%
- Other 9%
- Hospital 4%

What’s better? 4,000 new patients or 1,000 repeat customers?

Medicare Admissions

- New Patient: 37%
- Repeat Customer: 63%

Weekly Medicare Admissions

~Floridean Healthcare, Census 2014
Lifetime Nursing Home Use Probabilities

- Admission to nursing home is estimated at 44% for men and 58% for women
- Discharge from nursing home is estimated at 84% for men and 84% for women
- Is projected to increase with greater life expectancy among Baby Boomer retirees
- Average number of stays in 2 years = 1.2

“Readmissions” is not a 4 letter word

- Patient transferred to hospital that requests to return
- Patient that has elective surgery and makes choice for post-acute rehab
- Former patient with a family member needing skilled nursing services
- Visitor (Pastor, Rabbi) from the community asked to recommend skilled nursing services
- Patient needing outpatient services

End on a high note

- Customers don’t want to be in nursing home
- Confusing, frightening, no one listens
- Discharge is a chance to leave a lasting memory
- Medicare patients have a choice of post-acute care
- Customer Service = attention & communication
- Patient stay is an experience (good or bad)
- Patient wants individual care – discharge planning is a chance for one on one
- A satisfied customer is a repeat customer

What is Customer Loyalty?

- Customer loyalty is the result of consistently positive emotional experience, satisfaction and an experience, which includes the services.
- Customer loyalty can be said to have occurred if people choose to use a particular company, rather than use other companies.

Transitions of Care: Contrasting Scenarios

- Poor Care Transition
- Excellent Care Transition

The Perfect Discharge Home

- Services arranged before patient leaves
- Information on follow up appointments
- Explanation of foresee complications
- Medications given and explained
- Strong family support
ASHP & APhA project called for “Best Practices” involving pharmacists in the care transitions process.

In October 2012, eight programs were selected.

Criteria for selection:
- Impact of care transitions model on patient care.
- Pharmacy enrollment in transitions program was important in large settings.
- Adaptable in scale and operationalize for the institution and at sites by other health systems.


2010 Guideline developed by American Medical Directors Association.

Guidelines focus on specific concerns in the long-term care setting.

Transitional care: a set of actions designed to ensure coordination and continuity of care.


| TABLE 1.
Facility Pre-Discharge Checklist Issues That Should Be Addressed Before a Patient Transfers to Another Setting or Level of Care |
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>1. Review the patient’s medical record for the most recent documentation of all medications, current and discontinued.</td>
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<tr>
<td>2. Review the patient’s medical record for the most recent documentation of all medications, current and discontinued.</td>
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<tr>
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</tr>
<tr>
<td>10. Review the patient’s medical record for the most recent documentation of all medications, current and discontinued.</td>
</tr>
</tbody>
</table>

Challenges in D/C Plan

- Obtaining Prescriptions
- Chronic conditions
- Billing/Payment Issues
- Unreliable services

Medication Management in Discharge Planning

- Hassle free
- No driving, parking, waiting
- Payment Issues resolved
- Drugs in hand
- Pharmacy follow up

Risk Factors SNF patients

- Transitions in and out of Health Care System
- Higher number of RX and OTC compared to younger patients
- Age-related physical and mental capabilities
- Higher prevalence of chronic diseases
- Isolated seniors
- Non-English speakers
- Financial challenges

Hospital Readmissions, Medication Errors and Adverse Events

- Poor transitions are the leading cause of medication errors
- 22.4% of SNF discharges have subsequent health care use due to transition problem
- Lack of coordination between prescribers across settings
- Medication changes occur in 20% of transfers between nursing homes and acute-care hospitals

American Medical Directors Association. Transitions of Care in the Long-Term Care Continuum Clinical Practice Guideline. Columbia, MD: AMDA 2010

Medication Reconciliation

- Medication reconciliation is the process of creating the most current, complete and accurate list and comparing against orders at each stage of the stay
- Reconciliation-related errors
  - 22% during admission
  - 12% at discharge
- Joint Commission has made medication reconciliation at care transitions a National Patient Safety Goal
- CMS guideline for nursing facilities requires a medication regimen review by a consult pharmacist at least monthly
- Medication review should occur upon SNF admission and may reduce the incidence of complications or adverse events

American Medical Directors Association. Transitions of Care in the Long-Term Care Continuum Clinical Practice Guideline. Columbia, MD: AMDA 2010

Medication Management

Current Model for planned discharge

1. Prescriptions obtained from MD
2. Prescriptions given to patient
3. Patient Discharged
4. Prescriptions taken to Pharmacy
5. Medications picked up from Pharmacy
Medication Management
Best Practice for planned discharge

- Fax discharge orders to pharmacy
- Pharmacy delivers medications to facility
- Medications explained to patient
- Patient Discharged with medications
- Pharmacy follows up with patient at home

Elements for Success
Care Transitions Best Practices

- Multidisciplinary support and collaboration
- Effective integration of the pharmacy team
- Electronic patient information and data transfer
- Strong partnership network
- Data available to justify

Common Barriers
Care Transitions Best Practices

- Financial
- Communication
- Weak partnerships
- Information & Data
Does your facility have a Medication Management Program?

How to Implement a Medication Management Program

- Start discharge planning upon admission
- Medication Reconciliation upon admission
- Consultant pharmacist review medication regimen
- Identify patients with Medication Management issues
- Medication list explained to patient/care giver and questions answered
- Post discharge communication with patient

Conclusion

Care Transitions Best Practices

- Care transitions with a focus on medication management are well know to improve health outcomes and reduce hospital readmissions
- Pharmacist-driven medication management in care transition makes a significant difference in reducing overall health care spending
- Patients benefit from pharmacist's medication expertise and involvement in transition to home
On-Boarding for Success!

Educational Goals:
- Define on-boarding
- Determining your key ingredients
- Creating your on-boarding process
- Setting up the communications
- Determining who will be involved
- Expectations of a new hire mentor
- Follow up schedule

I suppose he is “On a Board”
What is On-Boarding
The process of helping new hires adjust to social and performance aspects of their new job quickly and smoothly.

Why on-boarding is important
1. Research and conventional wisdom both suggest that employees get about 90 days to prove themselves in a new job. The faster new hires feel welcome and prepared for their jobs, the faster they will be able to successfully contribute to the organization’s mission. (SHRM)
2. Half of all hourly workers leave their jobs within the first 120 days.
3. Used in conjunction with HRM best practices, effective on-boarding will result in a faster learning curve for new hires, improved communication, and a more productive and engaged workforce.

The trajectory of a new hire’s success is set as early as the first two weeks. It is important to make the first day a special one.
1. Well planned procedure, clearly defined expectations, and goals will make a great team member. Having a plan makes it easier to reach goals.
2. It will help employee understand their role.
3. It provides a training plan for mentors and key staff.
4. It will show your dedication to them.

Mentor:
1. Involve “C” level management team members.
2. Inspire, encourage and praise your new employee.
3. Provide feedback that can flow both from you to the employee and vice versa.
### Creating your Process

#### Before their first day

1. Prepare the paperwork
2. Discuss role, goals, and duties with their supervisor
3. Prepare workstation
4. Give access to any tools they might need
5. Create accounts
6. Assign required reading
7. Prepare benefit package
8. Provide a job description with responsibilities

#### First day

1. Be ready to welcome your new team member
2. Tour of your facility
3. Explain your expectations (be honest)
4. Induct into company culture
5. Assign a mentor
6. Share a break or lunch with them

#### First Week / Month

1. Assign 1st project
2. Explain expectations for following week and ask for a self assessment
3. Provide your feedback – Mention high points
4. Assign a mentor
5. Share a break or lunch with them
Creating your Process

1. Days 45 through 180
   1. On day 45, hold a “How are things going” meeting
   2. Discuss their perceptions and those from your team
   3. Point out strengths and areas of improvement
   4. Listen to them
   5. Invite them to corporate sponsored event
   6. Be available for phone conversations
   7. Check in with mentor
   8. Day 90: Have a formal Review (Ask employee for self assessment prior to this meeting)
   9. Watch for mood or personality shifts and ask the tough questions
   10. If applicable, ask them to be a mentor
   11. At 180 days share a break or lunch with them

Organizational flow chart

Setting up your communication channels

1. Organizational flow chart
   1. Provide your new employee with a management flow chart and make introductions
   2. Discuss role of mentor and how they can be contacted
   3. Provide key contact information
   4. Discuss open door policy and chain of command as related to reporting
   5. Define personality types of each direct report your employee will have
   6. Set expectations for communication
Determining who will be involved

1. Quick answer: EVERYONE is involved
   - CEO, CFO, Administrator, and all Directors should be introduced when available
   - For regional or national organizations use website or pictures. Try to give a brief description of that person
   - Department heads:
     - On tour ask each department head to describe their department and how they could interface
   - Direct manager:
     - Have this person be at least 50% of the first 45 day period of training
   - Peers:
     - Discuss the strengths of such as you introduce. This helps continue their on-boarding
   - Subordinates:
     - You will show them respect and build open communication but have set down the command chain

New Employee Mentor

1. This is a pivotal choice. Don’t make it lightly!
   - Make sure you know where the employee’s satisfaction is.
     - Just because a person smiles at you doesn’t mean they are on your side!
   - Your choice will set the tone for your new employee’s perception of your company.
   - Set expectations for mentor.
     - The new employee mentor should be keeping you in the loop as to how it’s going.
   - Use this mentor as a management training tool for up and coming employee’s.
     - Explain this to your choice and again use it as part of their on-boarding.

Questions?
Only 21% CEOs felt they got their money’s worth when they hired. A survey of top HR executives at 25 of the global 50 found that:

80% of external hires were disappointments.

Top 25% vs bottom 25%?
How many of did you expect to end up in the bottom 25%?

What does your curve look like?

What is the cost of under-hiring?
- Poor patient care
- Higher costs
- More accidents
- More mistakes
- Low productivity
- Higher turnover
- Higher legal costs
What You Hire

Native

Acquired

Genetics, behaviors and cognitive directly correlated to workplace performance.

6%

23%

27%
Job Success = Know + Do

**BEHAVIORAL**
- Motivation
- Drive
- Tendencies
- “Do”

**Conscious**
- Learning
  - Adapting to Change
  - Problem solving
  - “Know”

**PI Behavioral Assessment & PI Learning Indicator**

BEHAVIOR FIT + LEARNING SPEED = HIGH PERFORMANCE

**Behavior**
- Take charge or follow
- People or tasks
- Intensity or calmness
- Flexibility or organization

**Learning Speed**
- Training success
- On-the-job learning
- Acquiring information for decisions and problems
- Figuring out details of change
Hire Right, Manage Smart: A Scientific Approach to Human Capital Excellence

Steve Waterhouse
CEO
Predictive Results