Weekly Roundup

...Reporting the state and national long term care news

Please disseminate relevant information to the appropriate department.

☐Administration ☐Nursing ☐Dietary ☐Activities ☐ Social Services
☐Rehabilitation ☐Housekeeping ☐ Maintenance ☐ Laundry

Friday, March 15, 2013

ANHA NEWS

Registration Open for Mid-Year Convention

Registration is now open for the 2013 ANHA Mid-Year Convention which will be held April 29-May 2. This event features national and state speakers leading seminars on timely topics of importance to all nursing home staff. *See the attached brochure and registration forms for more information about the education offerings and CEUs.*

Reserve Your Hotel Room for ANHA Mid-Year Convention

You may now reserve your room at The Perdido Beach Resort for the 2013 ANHA Mid-Year Convention. Reservations can be made online at www.perdidobeachresort.com or by calling 1-800-634-8001. Remember to use ANHA group code number 6871. To ensure availability of rooms, all participants are encouraged to make overnight reservations by April 2, 2013.

The following rates have been negotiated for Mid-Year Convention Attendees:

- $169.00 per Standard/Double Room
- $229.00 per Gulf Front Single/Double Room

April 1 is the Deadline for 2013 ANHA Dues

Monday, April 1 is the deadline for payment of the 2013 ANHA membership dues. Facilities that have not paid their dues in full or have not established a payment plan may be dropped from the membership. Please contact Pat Williams at the Association Office at (334) 271-6214 or pwilliams@anha.org if you have any questions or want to set up a payment plan.

ANHA Partners with the National Center for Disaster Medical Response, University of South Alabama Center for Strategic Health Innovation

The Alabama Nursing Home Association has been working with the National Center for Disaster Medical Response, University of South Alabama Center for Strategic Health Innovation in the development of a training program specific for nursing homes. In addition, we have jointly prepared a Disaster Planning Guidance Manual regarding Sheltering in Place and Evacuations. To roll out the manual, we will be jointly presenting seminars across the state.

This specific ARRTC Road Show is a three (3) hour course designed for key administrators and staff at all healthcare facilities in the state. Four (4) Road Shows will be offered at sites throughout the state. The goal of this training is twofold: to bring ARRTC training on site to

healthcare facilities across the state, thereby allowing participation by more staff; and to invite regional neighbors/response partners to the training for purposes of establishing and enhancing a common knowledge of the basics of disaster response for healthcare facilities.

Key topics include: Intro to Hospital Incident Command System (HICS), National Incident Management System (NIMS) and National Response Framework (NRF); NIMS Compliance Requirements; Alabama Incident Management System (AIMS); Hazard Threat and Vulnerability Assessment and Disaster Response Plans; Altered Standards of Care; Chemical and Radiological Awareness; Biological Awareness; Decontamination and Personal Protective Equipment; Surge Capacity and Resource Management; Emergency Operations Center Activities; Medical Needs Shelters, Medical Reserve Corps; Strategic National Stockpile and Points of Dispensing; Evacuation; Fundamentals of Efficient and Effective Patient Handling during Evacuation; and current topics and unique events requested by ADPH.

The ARRTC Road Show is designed for individuals charged with disaster response leadership for their organization. The registration is FREE, but is required! The training will be held at the following dates and times:

April 11	Huntsville	8:00 a.m.
April 30	Orange Beach	1:00 p.m.

Please see the attached flyers for registration information.

"OSHA Recordkeeping and Workplace Safety for Long Term Care Facilities" Educational Seminar - April 3

Please mark your calendars for April 3, 2013, as ANHA will present a seminar entitled "OSHA Recordkeeping and Workplace Safety for Long Term Care Facilities." This seminar will be held at The Wynfrey Hotel in Birmingham. The seminar will begin at 9:00 a.m. and conclude at 3:00 p.m. This program has been approved for 5 hours of continuing education credits by the Alabama Board of Examiners for Nursing Home. It has also been approved for 6 contact hours of continuing education for nurses. The Alabama Nursing Home Association is an approved provider by the Alabama Board of Nursing (ABNP0151- expires 3/12/2017). *Please see the attached flyer for more information.*

AIT/Preceptor Certification & Recertification Training Seminar – April 2

The "AIT/Preceptor Certification and Recertification Training" Seminar will be presented on April 2, 2013, at The Wynfrey Hotel in Birmingham. All individuals interested in becoming a licensed nursing home administrator must complete a board approved Administrator-In-Training (AIT) Program. The Board has rules and regulations regarding entry-level requirements for nursing home administrators, the length of the AIT program for applicants and the qualifications for becoming a certified preceptor. This session is designed to certify licensed nursing home administrators who are interested in conducting an AIT program in their facility as preceptors.

In order to qualify to become a certified preceptor, individuals must have been a licensed and practicing administrator in Alabama for at least three years, or have been a licensed nursing home administrator for at least two years in another state and have been licensed and practicing in Alabama for at least one year, with no disciplinary action having been taken against them in the last three years. Preceptor certification and re-certification, once approved, lasts for three years. This seminar has been approved for 3 hours of CEUs for nursing home administrators. *Please see the attached flyer for more details.*

Call for Nominations: Alabama's Best Practices

Will you share your Best Practice? You are invited to share your knowledge, positive ideas, creativity and communicate with other professionals as we continue to strive to meet the needs of our long term care residents. *Attached is the 2013 Alabama's Best Practices "Call for Nominations."* We encourage each of you to look over the nomination form and submit your Best Practice. This year's Best Practices Program is scheduled for Thursday, August 29. Nominations are due April 19.

NATIONAL NEWS

CMS Releases More Memoranda – F155, F322, Physician Delegation of Tasks

The Centers for Medicare and Medicaid Services (CMS) released to the states three memoranda, each revising previous versions:

- Advance Directives (F155)
- Naso-Gastric Tubes (F322)
- Physician Delegation of Tasks in SNFs and NFs

In addition to the memoranda and guidance, the revisions to Advance Directives and Naso-Gastric Tubes are reflected in revised surveyor training materials. See attached documents for complete details.

F-Tag 155: Advance Directives (replaces previous version of S&C 12-47-NH dated September 27, 2012)

The revisions are highlighted in the Advance Copy Interpretive Guidelines and include:

- Removal of the term "right to accept" preceding language specific to medical and surgical treatment to correlate with the regulatory language at §483.10(b)(4).
- Language specific to experimental research has been added to the Interpretive Guidance (IG) and correlates with the Power Point training materials. A definition for investigational or experimental drugs has been added to the definitions sections of the IG.
- Clarification to specify that §483.10(b)(8) applies only to adult residents and not all residents regardless of age, as evidenced in the regulatory language.
- The Investigative Protocol has been updated to include guidelines specific to experimental research and record review considerations relative to a physician's basis for conscientious objection and/or need for additional information related to a resident's decisional capacity.
- The "Use" section of the Investigative Protocol has been revised secondary to burden reduction considerations. Surveyors will no longer use the protocol for <u>all</u> residents in the survey sample, only residents who meet the parameters listed in this section.
- Updated Power Point training slides to correlate with revisions made to the Surveyor Guidance at F tag 155. Revisions made to the training slides have a red font color.

F-Tag 322: Naso-Gastric Tubes (replaces previous version of S&C 12-46-NH, dated September 27, 2012)

The revisions are highlighted in the Advance Copy Interpretive Guidelines and include:

- Revision of the regulatory language to now resemble the formatting of §483.25(g) in the Code of Federal Regulations (CFR).
- Additional clarification related to the expanded definition of "Naso-Gastric tubes."

- Updated Power Point Training slides to correlate with revisions made to the Surveyor Guidance at F tag 322. Revisions made to the training slides have a red font color.

Physician Delegation of Tasks in SNFs and NFs (replaces S&C-04-08, dated Nov. 13, 2003)
CMS is clarifying the regulatory differences concerning physician delegation of tasks in SNFs and NFs. The distinction in policies between these two settings (SNFs and NFs) is based in statute and regulation. Improper application of these regulations may affect a facility's compliance and may also affect payment to providers.

The key to accurate application is to identify:
(1) in which setting, SNF or NF, the physician services are being provided;
(2) whether the task must be performed personally by the physician; and
(3) whether or not the non-physician practitioner (NPP) is employed by the facility.

The "setting" is determined by whether the visit to a patient in a certified bed is to a resident whose care is paid for by Medicare Part A in a SNF or under Medicaid in a NF. The memorandum addresses the authority of NPPs (i.e., nurse practitioners, physician assistants, or clinical nurse specialists) to perform certain tasks, such as conducting physician visits and writing orders, and to sign certifications and re-certifications.

Summary of elements of the memo:
- **Guidance revision:** Clarification of Federal guidance related to physician delegation of certain tasks in SNFs and NFs to non-physician practitioners (NPPs; formerly "physician extenders") such as nurse practitioners, physician assistants, or clinical nurse specialists
- **Implements Section 3108 of the Affordable Care Act (ACA):** Implements section 3108 of the Affordable Care Act, which adds physician assistants to the list of practitioners that can perform Skilled Nursing Facility (SNF) level of care certifications and re-certifications.
- **Co-signing of orders:** Clarifies policy on co-signing orders in SNFs and NFs

S&C Memo: Luer Misconnections

The Centers for Medicare and Medicaid Services (CMS) issued the *attached Survey & Certification Letter, S&C: 13-14-ALL,* highlighting the continuing risk of Luer misconnections in health care settings, suggesting actions providers can take to reduce the likelihood of these events; and actions surveyors should take when investigating these events.

Summary:
- **Luer Misconnections continue to result in adverse events and deaths –** Luer connectors easily link many medical components, accessories, and delivery systems. Clinicians, in any type of provider or supplier setting, can mistakenly connect the wrong devices and deliver substances through the wrong route. Despite numerous alerts and warnings, a patient's blood pressure tubing was recently misconnected to an intravenous (IV) line in an ambulatory surgery center (ASC) resulting in a patient death.
- **Adverse Event Complaint Investigation:** During a complaint investigation for an adverse event involving delivery of an incorrect substance or utilization of an incorrect delivery route, surveyors must be alert to whether the event involved misconnection of a Luer device. If so, surveyors must determine whether the facility has taken actions to ensure systems are in place to prevent recurrence of this type of adverse event.

- **Facility Reporting to Food & Drug Administration (FDA):** Surveyors should encourage health care facilities to report problems with Luer misconnections to the FDA, even if no adverse event occurred.

Examples of actions providers and suppliers can take to reduce the likelihood of Luer misconnections include, but are not limited to:

- changing to devices already on the market with alternative connector designs which reduce the likelihood of misconnections of incompatible lines;
- tracing lines back to their origins when reconnecting devices;
- positioning catheters and tubes that have different purposes on different sides of the patient's body or in unique and standardized directions; and
- implementing a multidisciplinary facility approach to address Luer misconnections.

S&C Memo: Resources Available for New Dining Standards of Practice

The Centers for Medicare and Medicaid Services (CMS) has issued the attached S&C memo with information regarding resources available to support the new dining practice standards. These standards address issues including expanding dining, therapeutic diets, food consistency, thickened liquids and tube feedings. The memo notes that, "Research presented revealed little benefit to many older individuals with chronic conditions from restrictions in dietary sugar and sodium, as well as little benefit from tube feedings, pureed diets and thickened liquids. The new standards recommend to clinicians and prescribers that a regular diet become the default with only a small number of individuals needing restrictions."

The memo provides links to the complete practice standards document and to a surveyor training video that introduces the 10 categories of changes.

While CMS notes that the new practice standards do not represent CMS requirements, they encourage surveyors to be aware of these changes as Quality of Care compliance is to be reviewed based on standards of practice. They also state that, "Surveyors should not issue deficiency citations simply because a facility is not following these particular recommended practices. However, facilities that opt to adhere to these practice standards may rely on such adherence in response to questions regarding any changes from more restrictive diet protocols previously used."

A Note from CMS: Mandatory Payment Reductions in the Medicare Fee-for-Service (FFS) Program – "Sequestration"

This message is directed at the Medicare FFS program (i.e., Part A and Part B). ***In general, Medicare FFS claims with dates-of-service or dates-of-discharge on or after April 1, 2013, will incur a 2 percent reduction in Medicare payment***. Claims for durable medical equipment (DME), prosthetics, orthotics, and supplies, including claims under the DME Competitive Bidding Program, will be reduced by 2 percent based upon whether the date-of-service, or the start date for rental equipment or multi-day supplies, is on or after April 1, 2013.
The claims payment adjustment shall be applied to all claims **after determining coinsurance, any applicable deductible, and any applicable Medicare Secondary Payment adjustments**. Though beneficiary payments for deductibles and coinsurance are not subject to the 2 percent payment reduction, Medicare's payment to beneficiaries for unassigned claims is subject to the 2 percent reduction. The Centers for Medicare & Medicaid Services encourages Medicare

physicians, practitioners, and suppliers who bill claims on an unassigned basis to discuss with beneficiaries the impact of sequestration on Medicare's reimbursement.

Questions about reimbursement should be directed to your Medicare claims administration contractor.

Sequester Application to Part A SNF PPS RUG Rates and Part B Rates for Part B Services Provided in Nursing Facilities

The following are the two most frequently asked questions directed to the American Health Care Association (AHCA) staff regarding sequester. They refer to the timing of the sequester and the application of the 2% cut to the RUG categories.

As of Thursday March 7, 2013, CMS had not answered these questions directly (although late Friday, March 8, 2013, CMS provided a notice that helps address the timing of sequestration, as set forth in Question # 1 below). Our understanding of the application of the sequestration is based on a reading of legislation, the opinion of counsel and currently-available information. ***Please see also the attached memorandum from Reed Smith, General Counsel to AHCA***, posted on-line on March 4, 2013 by Debra A. McCurdy, *Medicare and Sequestration - What Happens Now?*

AHCA will provide all members with up-to-date information as it becomes available.

1. Timing -- Application to Services Provided on or after April 1, 2013

Q: Will the 2% sequester reduction apply to claims submitted on or after April 1, 2013 or services provided on or after April 1, 2013?

A: On Friday, March 8, 2013, CMS issued an e-news alert, which we provided to AHCA members, indicating that in general, Medicare Fee for Service (FFS) claims with *dates-of-service* or dates-of-discharge on or after April 1, 2013, will incur a 2% reduction in Medicare payment. We believe that the date-of discharge pertains to hospital inpatient DRG claims, and that respect to the SNF PPS, sequestration will apply to dates of service on after April 1, 2013 (although neither the CMS guidance nor the sequestration statute address this directly). Thus, we expect that providers can split bill for stays that cross over from March to April. Thus, providers can bill as they have in the past – cutting off and billing through month end.

With respect to Part B, claims for dates of service on or after April 1, 2013 will be subject to the 2% reduction in Medicare payment.

CMS indicated in its Friday, March 7, 2013 notice that the claims payment adjustment shall be applied to all claims after determining coinsurance, any applicable deductible, and any applicable Medicare Secondary Payment adjustments.

2. Equal Application of the Rate Reduction of 2% Across All RUG Categories

Q: Will the 2% cut apply to RUG rates equally across all RUG categories?

A: AHCA believes that the 2% cut will be applied evenly across all the RUG rates based on the statutory sequestration language. Specifically, Section 256(d)(2) of the Balanced Budget and Emergency Deficit Control Act of 1985) (P.L. 99-177), as amended by Section 302 of the Budget Control Act , of 2011 (BCA, P.L. 112-25), provides that the sequestration reductions

applicable to Medicare "…shall be at a uniform rate, which shall not exceed 4 percent [2% under BCA], across all such programs and activities subject to" sequestration.

CMS Issues Directive: Prepayment Review for Therapy Claims at Threshold

The Centers for Medicare and Medicaid Services (CMS) updated its Manual Medical Review website (http://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medical-review/therapycap.html) and directed the Medicare administrative contractors (MACs) to conduct ***prepayment review*** on the Medicare therapy claims reaching the $3,700 threshold. CMS requested that MACs conduct these manual medical reviews within 10 days. CMS also indicated that this prepayment review was an interim measure and that it is developing a long-term strategy to deal with manual medical review.

The American Taxpayer Relief Act of 2012 (ATRA) extends the Medicare Part B outpatient therapy cap exceptions process through December 31, 2013. Section 603 of this Act contains a number of Medicare provisions affecting the outpatient therapy caps and manual medical review threshold.

The statutory Medicare Part B outpatient therapy cap for occupational therapy (OT) is $1,900 for 2013, and the combined cap for physical therapy (PT) and speech-language pathology services (SLP) is also $1,900 for 2013. This is an annual per-beneficiary therapy cap amount determined for each calendar year. Exceptions to the therapy cap are allowed for reasonable and necessary therapy services. Per beneficiary, services above $3,700 for PT and SLP services combined and/or $3,700 for OT services are subject to manual medical review. CMS is not precluded from reviewing therapy services below these thresholds.

The therapy cap applies to all Part B outpatient therapy settings and providers including:

- Therapists' private practices
- Offices of physicians and certain nonphysician practitioners
- Part B skilled nursing facilities (type of bill (TOB) 42X, 43X,44X)
- Home health agencies (TOB 34X)
- Rehabilitation agencies (also known as outpatient rehabilitation facilities or ORFs)
- Comprehensive outpatient rehabilitation facilities (CORFs)
- Hospital outpatient departments (HOPDs) (TOB 12X or 13X)

CMS is developing a long-term strategy to deal with manual medical review. At this time, there is no advance request for an exception process. Additional information will be provided on the MAC websites.

Section 603 (b) of the American Tax Relief Act counts outpatient therapy services furnished in a critical access hospital (CAH) toward a beneficiary's annual cap and threshold amount using the Medicare physician fee schedule rate. CAHs are not subject to the therapy cap, the manual medical review process, or the use of the KX modifier. You can contact CMS with questions about the therapy cap and new threshold via a designated email box at therapycapreview@cms.hhs.gov.

Problem Impacting Crossover of Medicare Part B Outpatient Therapy Claims

The latest Center for Medicare and Medicaid Services (CMS) Medicare FFS Provider e-News has the following notification regarding the processing of the new functional G-Codes. The

Middle Class Tax Relief and Jobs Creation Act of 2012, Section 3005(g) required **a claims-based data collection strategy that is designed to assist in reforming the Medicare payment system for outpatient therapy services**. AHCA is now reporting that a problem has occurred in the processing of the new G- codes.

CMS reports that:

Problem Impacting Crossover of Medicare Part B Outpatient Therapy Claims

Parties that bill for Medicare participating outpatient therapists, physicians, and non-physician practitioners (NPPs) may have recently noticed an increase in the incidence of the Health Insurance Portability and Accountability Act (HIPAA) rejection codes denoted below on their provider notification letters. Medicare routinely mails these letters out to providers, physicians/practitioners, and suppliers when various identified claims cannot be successfully crossed over to their patients' supplemental insurance companies.

- H51000: The Procedure Code ____ is not a valid CPT or HCPCS Code for this Date of Service
- H51061: 'Procedure Modifier 1' ___ is not a valid CPT or HCPCS Modifier Code
- H51062: 'Procedure Modifier 2' ____ is not a valid CPT or HCPCS Modifier Code
- H51063: 'Procedure Modifier 3' ____ is not a valid CPT or HCPCS Modifier Code
- H51064: 'Procedure Modifier 4' ____ is not a valid CPT or HCPCS Modifier Code
- H51108: _____ is not a valid 'Line Level Adjustment Reason Code.'

Note: Where you see "_____" directly above, the value (for example, G8978; modifier CH; or CARC 246) was reported, when applicable, on the outbound provider notification letter that billing offices would have received.

Unfortunately, the new functional G-codes, new severity/complexity modifiers, and new Adjustment Reason Code (CARC) 246 for the January 2013 Healthcare Common Procedure Coding System (HCPCS) and CARC updates were inadvertently not loaded. As a result, a moderate number of Part B outpatient therapy claims (claims for physical, speech, and occupational therapy) were rejected in error. The newly added severity/complexity modifiers were as follows: CH, CI, CJ, CK, CL, CM, and CN.

The new functional G-codes fall within the following ranges:

- G8978—G8999
- G9158—G9176
- G9186

Actions Taken To Remedy the Issue

The Coordination of Benefits Contractor (COBC) HIPAA validation vendor added the new G-codes to its HCPCS table as of January 28, 2013. The vendor then added the new severity/complexity modifiers to its HCPCS table as of February 11. Lastly, the vendor added the new CARC 246 to its table as of February 25. Thus, Medicare participating therapists, physicians, and NPPs should now see a *drastic decrease* in the incidence of error codes H51000, H51061—H51064, and H51108 reflected on their provider notification letters.

Affected Claims Need to be Billed Directly to Supplemental Insurers

If your billing office received a provider notification letter from Medicare indicating that claims could *not* be crossed over due to one of the H-series error messages described above, there unfortunately is *not* a way for Medicare to re-transmit the affected claims to your patients'

supplemental insurers. Therefore, you will need to bill your patients' supplemental insurers directly. CMS regrets that this is necessary.

Please know that to help mitigate this kind of problem in the future, CMS will implement a fail-safe strategy well in advance of the scheduled installation of new HCPCS or other code updates. This will ensure that any incorrectly rejected Medicare crossover claims will be repaired by all A/B MACs, thus appropriately minimizing the impact to the provider community.

STATE NEWS

ADPH: Reporting Abuse, Neglect and Misappropriation of Property

Editor's Note: The following article was provided by the Alabama Department of Public Health's Division of Health Care Facilities.

In an effort to save nursing facilities time and to accelerate the investigative review process, the Alabama Department of Public Health (ADPH) is requesting that specific information be included in the facility's five (5) day report. In particular, ADPH requires certain information pertaining to the named perpetrator in the reporting of abuse, neglect or misappropriation of property.

That information is as follows:

- The alleged perpetrator's full name
- Most current address known
- Social Security Number
- Date of birth
- Telephone number(s) (Note: If available, provide alternate telephone numbers such as their cell phone and the name and telephone number of the person designated to contact in case of an emergency.)
- Full name of witnesses with direct knowledge of the incident
- Most current address known
- Telephone number(s) (See note above)

Additionally, within the facility's investigation, the facility must provide a conclusion to their investigation. That conclusion should be specific to whether or not the facility was able to identify adequate proof that abuse, neglect or misappropriation of property occurred. For example, in many cases, the behavior of the named perpetrator is accurately concluded to be inappropriate, unprofessional, rude and/or in violation of the facility's policies and procedures and standards of care. In these cases, the named perpetrator's behavior would not have risen to the level of abuse as is defined by CMS in the State Operations Manual.

By providing such information as requested, the facility will often prevent the loss of a substantial amount of time supplying that information by telephone. It will also reduce the time and expense incurred when that information is provided by mail or parcel service. This cooperative effort will help in preventing delays and will enable ADPH to better expedite the investigation review process.

Medicaid Estate Recovery Reviews

Health Management Systems (HMS) has been contracted by Alabama Medicaid to perform estate recovery services. These services are for the recovery of medical assistance payments from the estates of certain deceased Medicaid recipients and/or their spouses. Nursing home providers will soon be receiving letters or a questionnaire from HMS requesting information in order to recover the costs of Medicaid services, when it is appropriate. HMS is working as an authorized agent for the Alabama Medicaid Agency and security agreements are in place for a provider to be able to release recipient and sponsor information to HMS.

Providers are asked to complete requests from HMS within two weeks of receipt of the notice. Questionnaires must be completely filled out with all requested documentation and faxed to (855) 809-3983 or mailed to HMS, The Alabama Medicaid Estate Recovery Contractor, P.O. Box 166709, Irving, TX 75016-6709. Any questions about any letter or questionnaire should be referred to HMS at (855) 543-8395. Any questions that need to be directed to the Agency regarding the estate recovery services being performed by HMS can be directed to Keith Thompson at (334) 242-5248.

Medicaid Update

There seems to be some confusion about Medicaid not having this information available to the public or to nursing homes. ANHA has been asked to help spread the word with the document references below. Medicaid has been working diligently with ANHA and its members. Their managers, directors and deputy commissioners have been visiting nursing homes around the state asking about issues and any problems that they are having with Medicaid. Whenever it has learned about a worker asking for too much information or redundant information, or received a complaint about poor communication; Medicaid has addressed that with the manager so that consistency and improvements are achieved. Medicaid is addressing each complaint and is performing due diligence when issues are found by requesting counseling for the worker or providing additional training. ANHA is pleased with Medicaid's efforts. In our efforts of joint communication, we encourage you to utilize the references listed below.

Tips for Applying for Nursing Home Medicaid:
http://www.medicaid.alabama.gov/documents/3.0_Apply/3.2_Qualifying_Medicaid/3.2_Nursing_Home_Medicaid_App_Tips_11-5-12.pdf

Helpful information: Medicaid for the Elderly and Disabled:
http://www.medicaid.alabama.gov/documents/3.0_Apply/3.2_Qualifying_Medicaid/3.2_Medicaid_Elderly_Disabled_2013_1-14-13.pdf

Important Information from the Alabama State Board of Nursing

The 2013 Annual Report of Standardized Procedures Report reflecting care provided in 2012 is now available online. As with previous reports, the 2013 report requires the CNO to update the report submitted for 2012 with edits, deletions or additions, thus decreasing the time factor for completion.

NOTE: If your facility/agency/company is part of a larger corporation, please contact your Corporate Nurse before proceeding. The Corporate Nurse may be completing one report for all facilities/agencies or companies within your corporation.

*As in 2012, facilities classified as Rural Health Clinics, FQHCs, Assisted Living and Specialty Care Assisted Living facilities are **NOT** required to report.*

To access the 2013 report, go to the ABN website (www.abn.alabama.gov); From the title bar or top menu, select **Nursing Practice**; select **Standardized Procedures**. Then click on the **2013 Standardized Procedures** link from the menu on the LEFT side of the page.

The **deadline** for the 2013 Annual Report of Standardized Procedures for Hospitals, Nursing Homes, Ambulatory Surgery Centers, Home Health, Hospice, ESRDs, Medical Transport Companies, Abortion Centers, Infusion Companies and the State Correctional facilities is **April 15, 2013**. Please contact Carolyn Morgan for any questions at carolyn.morgan@abn.state.al.us or (334) 293-5200.

FACILITY NEWS

New Twist on National Nursing Home Week

The roots of National Nursing Home Week (NNHW) are a singular focus to honor the seniors and other residents served by the long term and post-acute care community. For 2013, this tradition recognizes that residents and families can play a vital role in care planning and its daily implementation.

That sentiment is spotlighted by our 2013 theme of "Team Care: Everyone Pitches In!"

Throughout the week of May 12–18, 2013, skilled nursing facilities across the nation will celebrate NNHW with open houses, tours welcoming VIPs and the community's "friends of long term and post-acute care," and special events for the residents, families, staff and others. The kick-off day for NNHW is Mother's Day!

Team Care itself is meant to personify the many professionals and caregivers whose dedication and work ethic contributes to achieving care excellence and high levels of satisfaction. Families and the public may not realize the breadth of expertise Team Care brings to the bedside and throughout a resident's day. Our "customers" may also not realize that they too can be active members of Team Care; to fully initialize a person-centered protocol their input is important.

Team Care should be on display at your facility by using special themed products that are available from the AHCA Bookstore. Order soon as quantities are limited. More information is available at the dedicated web site www.nnhw.org and on Facebook.

Let's show the world class spirit of care communities across the nation this NNHW by reaching out to all friends of quality health care. We are all more effective with Team Care spirit humming along at full throttle as Everyone Pitches In!

National Nursing Home Week T-Shirts

Jones Sportswear is offering National Nursing Home Week t-shirts. *Please see the attached flyer from Jones Sportswear for more information.* NNHW begins on Mother's Day, May 13 and lasts until May 19.

OTHER NEWS

New ACO Webinar Series in Partnership with the Advisory Board Company

The American Health Care Association (AHCA) has partnered with The Advisory Board Company to provide members with two new webinars on Accountable Care Organizations (ACOs). The ACO market is rapidly evolving, and AHCA continues to stay on top of emerging trends in order to provide the most relevant, up-to-date information for post-acute and long term care providers. The Advisory Board is a health care research and consulting firm and one of the leading authorities on delivery system and payment reform.

The first webinar, *"Preparing Post-Acute Providers for Accountable Payment,"* will explore the new incentives providers will face, the levers they must employ to excel in a market that rewards value over volume, and the key implications for post-acute and long term care providers.

Members will learn about:

- The current state of risk-based payment adoption in the United States
- Delivery system responses to changing market incentives
- The implications of payment and delivery system evolution for post-acute and long term care providers
- Six critical imperatives to position for market success

This first webinar will take place on **Wednesday, March 20, at 12:00 p.m.** Click here to register: http://ns.advisory.com/Post-Acute-Care-Collaborative-Webconference-Preparing-post-acute-providers-for-accountable-Direct

The second webinar will take place on Wednesday, May 8, at 12:00 p.m., and additional information and a registration link will be provided closer to that date.

CALENDAR OF EVENTS

Date	***Event***	***Location***	***Time***
March 19	ANHA Region VI Meeting RSVP: Jennifer Agee jennifer.agee@northporthealth.com	ANHA Office Montgomery	10:30 a.m.
March 21	ANHA Executive Board Meeting	ANHA Office Montgomery	10:00 a.m.

March 27	ANHA Region I Meeting RSVP by March 25 Cindy Lewis (256) 739-1430 or clewis@usahealthcare.net Sponsor: Healthcare Services Group	Rigatoni's Florence	12:00 p.m.
April 11	ARRTC Road Show Disaster Training	Westin Hotel Huntsville	8:00 am
April 25	ANHA Region III Meeting RSVP: Kevin Ball (205) 788-6330 kball@ballhealth.com Guest Speaker from Alabama Medicaid Agency	Kirkwood by the River Birmingham	12:00 p.m.
April 29- May 2	ANHA Mid-Year Convention	Perdido Beach Resort Orange Beach	
April 30	ARRTC Road Show Disaster Training	Perdido Road Show Orange Beach	1:00 pm

Alabama Nursing Home Association
4156 Carmichael Road ◆Montgomery, AL 36106◆PH: (334) 271-6214◆FAX: (334) 244-6509

WEB SITES:

Alabama Nursing Home Association http://www.anha.org
AL Board of Examiners of Nursing Home Administrators http://www.alboenha.state.al.us
AL Dept. of Public Health http://www.adph.org
CMS http://cms.gov