NATIONAL ASSOCIATION OF LONG TERM HOSPITALS
NALTH

NALTH News

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PRESIDENT'S MESSAGE

The NALTH Board of Directors has been very actively involved on your behalf since our annual meeting in April. As your governing body we have been focusing our efforts on many important projects, but here are a few for your information:

- The major LTCH Joint Industry Criteria Study, the research project with ALTHA, the Federation, AHA, with research and management by KNG Health Consulting LLC, and the Lewin Group.
- A Task Force has been actively working on a payment study for LTCH's with the support and expertise of KNG Health Consulting LLC. Research with consultants is ongoing. Phase I has been completed and Phase II authorized by the NALTH Board. This will be another opportunity to validate that LTCH's do save the federal government money.
- We renewed our contract with Association Resources, the management agency hired to manage NALTH.
- Forecasting and preparing our 2011 Budget for fiscal year end on September 30th.
- Preparing for our annual dues processing.
- Offering the NALTH Coder Audits and on-site training as requested by LTCH's.
- Creating a unique LTCH Database that measures quality and operational data with the support and expertise of Association Resources.
- Demonstrating NALTH's NHIS Database and signing up new participants. Providing NHIS Webinars and assisting our members. Preparing for the next NHIS Contract period in 2011.
- The Education Committee has worked for one year to prepare a clinician educational opportunity at our Mid-Year meeting in Las Vegas on October 21 and 22, 2010.
- Health Reform and how it may affect LTCH's. Studying potential ACO's, the Continuing Care Hospital concept are all being reviewed and NALTH will continue to work with our members on task forces to help develop or prepare for potential demos. We are vested in determining how we can help our members and the LTCH industry in the future.

Many of our board members are investing time and effort to volunteer and participate on various committees and task forces for NALTH and LTCH's in general. They also offer the assistance of key experts from their facilities to participate on numerous committees.

NALTH's NHIS Database will be renewed for a three year period in 2011. In the past few months the NHIS Subcommittee and contractors have been marketing to potential participants offering Webinar training and for a limited time we are waiving our sign up fee if the institutions agrees to sign up for our 3-year commitment renewal next year. As we are all aware, quality and benchmarking are the gold standard that we are being benchmarked by. Participation in the NHIS Database is a voluntary, quality benchmark designed by NALTH with consultants. We have a very robust and unique system that not only looks at patient quality and outcomes but adds in many operational benchmarks not found in other products similar to ours. Included within the 3-year fee is ORYX Indicators for the Joint Commission reporting requirements. If you are a current NHIS participant we are hoping you continue in the renewal of NHIS since we feel that soon quality benchmarking will be a requirement by CMS. If you participate in some but are not fully supplying all data we encourage you to work with our consultants so that we can get more substantial benchmarking data with more participation. If you have not signed up 1yet, or only partially participate, please allow Sue Glasser, our contractor to work with you and set up a Webinar soon.

We hope that our "Webinar for Members Only" on September 8th was of value and would like to know if this venue was more beneficial than holding just teleconferencing as we have in the past. We are attempting to use the most current technology to get information to you in real time and with limited cost and effort on behalf of the members.

On October 21 and 22, 2010, NALTH will be hosting our Mid-Year meeting in Las Vegas, Nevada at Treasure Island. With the Mid-Year meeting we reach out to our clinicians and host many excellent, educational updates. We hope that these clinical topics are of interest to you and your staff and certainly look forward to your attendance. We will also be hosting a CEO Summit on Friday, October 22 at Treasure Island for the CEO's, COO's and CFO's. We are hoping that the decision makers will be able to at least attend this special session so that we can listen to your input and discover what our membership needs from us. We also would like to share our thoughts and plans for NALTH. The NALTH Board of Directors hopes to meet with our members at this CEO Summit so that we can plan and prepare for our future. Mr. Ed Kalman, General Counsel will be sharing his views and vision. Lane Koenig, KNG Health Consultants will be present to share his research concepts.

As always I wish to thank you for your membership and offer that you may contact me at your convenience to share your ideas or concerns, NALTH is your organization and I am vested in supporting you in your endeavors. I hope to see you in Las Vegas for our Mid-Year Meeting and Educational Session. We have an excellent venue to share with you.

Cheryl A. Burzynski

THIS ISSUE...

President's Message 1
Member Spotlight 2
Member Research & Innovation 4
Health Reform Policy & Regulatory Update 5
NHIS Update 7
Feature Article: A CMS Validation Survey: One hosptital's Experience 8
Leadership 11

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NALTH encourages the submission of articles for publication. For more information, please contact

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NALTH CALENDAR

October 20, 2010
NALTH Board Retreat
(Board Members Only)

October 21-22, 2010
NALTH Education Conference
Multidisclipinary Frontiers in Treating the Long Term Care Hospital (LTCH) Patient
Treasure Island Hotel, Las Vegas, NV

April 27, 2011
NALTH Board Retreat
(Board Members Only)

April 28-29, 2011
NALTH 2011 Annual Meeting
Omni Shoreham Hotel,
Washington, DC

New England Sinai Hospital NALTH Founder and Leader in Pulmonary and Long Term Acute Care

Renowned as a regional leader in providing specialized, pulmonary care, New England Sinai Hospital is a 212-bed, nonprofit, long-term acute-care hospital for patients requiring complex medical care, comprehensive pulmonary and acute rehabilitation, and specialized ambulatory services. Under the direction of Judith C. Waterston, President and CEO, Sinai's mission is to provide safe, respectful, high-quality care in a fiscally responsible manner.

A combination of medical excellence, compassionate care and a focus on patients and their families enables Sinai to deliver high caliber inpatient care at our main campus in Stoughton, and at inpatient satellite units at Tufts Medical Center in Boston and Carney Hospital in Dorchester. Sinai is a teaching affiliate of Tufts University School of Medicine and is accredited by The Joint Commission (TJC) and the Commission on Accreditation of Rehabilitation Facilities (CARF) for comprehensive integrated inpatient rehabilitation, outpatient medical rehabilitation and pulmonary rehabilitation programs.

NALTH Founder

In 1989, Sinai's then president Donald Goldberg, was a pivotal founding member of the National Association of Long Term Hospitals, and served as its first president. His vision, foresight and advocacy were instrumental in giving long term acute care hospitals a unified voice in matters of legislative, regulatory, policy and industry issues to advance the best interests of LTCH (long ternm care hospital) patients. In helping to establish this powerful organization, Sinai stands alone in gaining crucial recognition for the role that post acute care plays in the healthcare continuum. Sinai Chief Medical Officer Lawrence S. Hotes, MD, FACP, FACE serves on the NALTH Board of Directors and as Chair of two NALTH committees, the Physician Affairs Committee, which plans educational programs and sponsors physician advocacy, a forum for physician issues, and physician representation, and the Research Outcomes Committee, charged with developing research outcomes studies in LTCHs with an emphasis on demonstrating the unique aspects, positive outcomes, and cost savings of long term acute care. A specialist in Endocrinology & and Metabolism, Dr. Hotes has been a member of the Sinai medical staff since 1986.

History

Sinai was founded in 1927 as the Jewish Tuberculosis Sanatorium in Rutland, Massachusetts to care for those stricken by the tuberculosis epidemic. A vital link in the battle to control TB, the Sanatorium provided modern therapy and pioneered the use of streptomycin to treat TB. As new drugs made it possible to control tuberculosis, the focus shifted to patients with chronic diseases and those needing complex medical care. To meet this need, New England Sinai Hospital opened in Jamaica Plain in 1954. In 1976, Sinai opened a new hospital in Stoughton to care for medically complex patients who required prolonged hospitalization.

From the beginning, our personal and family style way of caring for patients set us apart. Our Compassionate Caregiver of the Year Award underscores our commitment to this philosophy.

Center for Medical Excellence

Many patients are transferred to Sinai directly from the intensive care unit of a major medical center or community hospital, are ventilator-dependent and require management of pulmonary and multiple, complex medical illnesses. Led by Lawrence S. Hotes, MD, Chief Medical Officer, Sinai's medical staff includes hospital-based and private practice attending physicians, and comprehensive consulting staff, holding degrees from the best medical schools and who have having received post-doctorate and specialty training at prestigious medical centers throughout the country. Our multidisciplinary medical/clinical teams of physician assistants, nurses, therapists and other allied health professionals are highly experienced in treating patients that require a lengthy hospital stay of 25 days or longer. Our broad array of inpatient programs for those suffering from catastrophic illness or injury includes: pulmonary care and rehabilitation; complex medical management; acute rehabilitation; wound management, hyperbaric oxygen therapy and telemetry.

A Leader in Pulmonary Excellence

Hailed as a leader in pulmonary medicine, Sinai's capabilities include technologically advanced methods to treat patients with an array of pulmonary conditions. We believe that weaning patients from the vent is as much an art as it is a science. Our 70-bed vent-weaning program is the largest in the region and we continue to meet and exceed national benchmarks for ventilator weaning. In addition, with state of the art equipment, such as our video bronchoscope, patients can undergo airway evaluations at the bedside. We use ultrasound guidance to help with line placement and to perform other procedures.

Under the leadership of board certified university trained pulmonologists, our expert therapists have achieved an outstanding level of excellence. In addition, Sinai participated in a national multi-center ventilator-weaning study published in Chest.

Sinai's pulmonary expertise also extends beyond the inpatient setting. Our pulmonary outpatient program is the largest in the region and works to keep our patients with complex pulmonary disease active and in the community. Our state of the art Sleep Laboratory, operating in collaboration with Sleep HealthCenters, performs over 700 sleep studies a year and our sleep clinic has expanded to meet the increasing demand for services. Now in its ninth year, our Breathing Easier Pulmonary symposium continues to position Sinai as a leader in educating health care professionals in how to provide optimal care to patients with pulmonary disease. The symposium attracts physicians and allied health care professionals from around New England seeking to learn the latest innovations, practices and theories in the care of patients with pulmonary disease.

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Clinical Research

A major teaching affiliate of Tufts University School of Medicine, Sinai is the home base of the residency program in physical medicine and rehabilitation, and a rotation site for Tufts pulmonary fellows. Tufts-affiliated pulmonary and critical care physicians and fellows keep Sinai at the forefront of pulmonary medicine. The Rose Kalman Research Center was established in 2007 following a generous bequest and is directed by Alexander C. White, MD, MS, Chief of Pulmonary and Sleep Medicine. The Center is focused on clinical research dedicated to patient care issues and processes in the LTCH setting. The Rose Kalman Research Center aims to improve outcomes of patients who are chronically, critically ill and examine the clinical questions germane to their care.

In collaboration with Tufts Medical Center physicians and researchers Usamah Kayyali, Ph.D., Nicholas Hill MD, Norma Terrin, Ph.D. and John Griffith Ph.D., Rose Kalman Research Center current research projects include: an analysis of ventilator associated pneumonia in a cohort of over 100 subjects; a study of decannulation following tracheostomy and an analysis of blood replacement treatments used in the long term acute care setting; analysis of acute discharges from Sinai back to an acute facility; terminal weaning in an LTCH as compared with a medical intensive care unit; organ repair and recovery in the first 30 days at a LTCH facility; establishing a web based clinical database of all patients undergoing prolonged mechanical ventilation; and establishing a tissue bank of blood samples obtained from patients undergoing prolonged mechanical ventilation.

Academic Programs

With our strong clinical relationships with nursing programs at local colleges, Sinai helps train the health professionals of tomorrow. For over 20 years, Sinai and Massasoit Community College have worked collaboratively to educate nursing students, and in 2008, we were awarded a $48,000 patient simulator from the Massachusetts Department of Higher Education to educate nurses and therapists, nursing students, faculty and staff. Training on simulators is a frontline tool to prevent medical errors and improve care with no risk to patients.

Focus on Patient Safety

With world class medical and clinical staff, Sinai was the first long term acute care hospital in the region to implement the electronic medical record administration and bar code bracelet system. By investing in information technology to increase safety and quality care for our patients we led the way in putting patient safety first. Our Simulated Living Center takes our expertise in rehabilitation to a higher level and helps motivate our patients to practice and master the skills they need for daily living and return home safety.

Serving the Community

As a community-minded organization and major area employer, Sinai offers a wide range of programs to residents of the local community and surrounding towns. Sinai is an active participant in local community organizations, such as the Massachusetts Hospital Association, Neponset Valley Chamber of Commerce, Metro South Chamber of Commerce and Stoughton Chamber of Commerce.

Every year, the hospital hosts a health fair with the Striar Old Colony YMCA, continuing a partnership that has been ongoing for more than 20 years. Free health and wellness screenings and programs for both children and adults attract residents from surrounding towns. Our dedication to the community earned us designation as the 2008 Nonprofit Business of the Year by the Neponset Valley Chamber of Commerce. Our Sinai Foundation increases our visibility as a fundraisingpartner in the community. Working with the local Rotary CorpsAdult Day Health Program, the Foundation sponsors an annual "Stepping Up Walkathon," to raise funds to enable frail older adults in the community to attend Sinai Adult Day Health Care Programs. Sinai's expertise in the management and education of chronic diseases is at the heart of the hospital's community outreach to improve the health of community members. Throughout the year Sinai participates in a variety of health fairs and offers screenings, prevention programs and educational activities. These include The Sinai Men's Associates hosting various community events, such as dinners, speaker series and a "Cycles for Sinai benefit run" to raise funds for patient programs. Our role as a fundraising partner also increases our visibility in the community as a resource for outpatient programs, wellness initiatives and long-term, acute care.

Our many community programs include:

Adult Weight Management Program

Diabetes Support Group, Diabetes Community Lectures, Pump Club for Insulin Therapy

Alzheimer's Caregivers Support Group and Education Series

Parkinson's Caregivers Support, Bereavement, Stroke, and Caregivers of Frail Adults Support Groups

2nd Tuesday Lecture Series dedicated to promoting good health

Annual Health & Fitness Expo and Stepping Up Walkathon

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Each NALTH newsletter will highlight a member hospital's outstanding program or community benefit. Please contact NALTH to suggest a member to spotlight.

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From left to right: Dr. Charles Wall, Massasoit Community College President, Lawrence S. Hotes, MD, FACP, FACE, Sinai Chief Medical Officer and Richard J. Cronin, Massasoit Acting Vice President of Student Affairs and Enrollment Management at a live demonstration of SimMan, the patient simulator. For over 20 years, Sinai and Massasoit Community College have worked collaboratively to educate nursing students.

We also partner with these organizations to provide education and information to the community:

Lions Club
Stoughton, Canton, Avon, Easton, Sharon Councils on Aging
Stoughton Senior Center
Stoughton Department of Public Health/VNA
Stoughton School Department (School Nurse)
Stoughton Youth Commission
Stoughton Rotary Club
Jewish Family & Children's Service
Hessco
Old Colony Elder and Hospice Services
MAB Community Services
Stoughton Fire, Police & Emergency Medical Personnel

Outpatient Services

Sinai also offers a full-spectrum of specialty outpatient services, anatural outgrowth of our inpatient rehabilitation care and a continuationof the commitment we have to our patients and ourcommunity to provide these services close to home. Outpatientscome from around New England to be treated at our Wound Center and receive hyperbaric oxygen treatments; undergo sleep studies through our Sleep Disorders Program and for treatment at our Diabetes Center, which has been recognized by the American Diabetes Association since 1993. The Diabetes Center at Sinai offers an array of services, classes, and support groups as the number of patients diagnosed with diabetes reaches epidemic proportions.

Outpatient therapy programs in physical therapy, speech therapy and occupational therapy address both the symptoms and theroot causes of the problem and are recognized for the excellentoutcomes our patients achieve. With individualized treatment plans and one-to-one treatment by our licensed clinicians, patients reach their goals as quickly as possible. Sinai has received numerous consecutive Focus on Therapeutic Outcomes (FOTO) Awards for exceeding national benchmarks on outpatient occupational and physical rehabilitation outcomes. Sinai's pulmonary expertise also extends to outpatient care and includes a pulmonologist-directed outpatient pulmonary rehabilitation program, which has seen outstanding results in helping people reduce shortness of breath, increase endurance and improve quality of life.

Website: **www.newenglandsinai.org**

NALTH Quality Achievement Award

Spartanburg Hospital for Restorative Care
Spartanburg, South Carolina

Rapid Response Team Performance Improvement Initiative

Wilson Smith, MD, Medical Director; Jill Jolley Greene, MSN, RN, Chief Nursing Officer;

James Michael Smith, RRT, Respiratory Manager; Carolyn Winchester, BSN, RN, Nurse Manager and the entire Code Blue Rapid Response Committee

Introduction / Purpose

The 100,000 Lives Campaign was an initiative launched by the Institute for Healthcare Improvement (IHI) in an effort to extensively reduce morbidity and mortality in healthcare. Building on the successful work of healthcare providers all over the world, IHI introduced six proven best practices to help participating hospitals extend or save as many as 100,000 lives ("Overview," n.d.). Due to the success of this movement, the IHI launched a second initiative, The 5 Million Lives Campaign, commissioning six additional interventions to reduce medical harm. The development and implementation of a Rapid Response Team was one of the original lifesaving strategies recommended by the IHI and supported by The Joint Commission who acknowledged the effectiveness of a formal recognition and response process by developing a National Patient Safety Goal to address this issue ("Improving Early Recognition," 2007).

As a participant in the 100,000 Lives Campaign and a Joint Commission accredited hospital, Spartanburg Hospital for Restorative Care (SHRC) implemented a Rapid Response Team. The Rapid Response Team is a team of clinicians who bring critical care expertise to the bedside in response to changes in a patient's condition. The goal of this performance improvement initiative was to implement a formal early detection process and to develop an organized team of responders to intervene 24 hours a day, 7 days a week to clinical signs of deterioration in order to prevent codes and save lives.

Methods

The SHRC Performance Management Council commissioned a Performance Improvement Rapid Response initiative, selecting a committee comprised of registered nurses, respiratory therapists, physical therapists, pharmacists, the Chief Nursing Officer, and the Medical Director to oversee the program. The group used the FADE process (focus, analyze, develop, and execute/evaluate) to develop and implement the Rapid Response Team, completing the following performance improvement steps:

Focus

The committee identified the need for a formal early detection process in order to circumvent unnecessary patient destabilization.

Analyze

The committee envisioned the Rapid Response Team as a proactive group of specialized individuals available around the clock. The members conducted an extensive review of literature in order to determine the best structure and process for the Rapid Response Team and evaluated available resources to determine the

...continued on page 6

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Law and Policy Report

By Edward D. Kalman, *General Counsel*

There are a number of significant new legal and payment policy developments that relate to the strategic interest of long-term care hospitals. NALTH has undertaken new research which is directed at determining whether the 25% rule, if fully implemented, would result in payment incentives which save or cost the Medicare program money. A key objective of this study is to make an empirical determination whether on an industry wide basis, over a combined short-term acute care hospital and LTCH episode of care, Medicare program payments are lower when patients are admitted from a short-term acute care hospital to an LTCH rather than reminding in a short-term acute care hospital. In addition this report reviews:

1) on going policy development on LTCH specific quality out come measures; a change in the way CMS will determine LTCH compliance with the mandatory LTCH 25 day ALOS certification requirement; and
2) The final conclusion of litigation over the Medicare program's obligation to pay interest in successful appeals from the " denial of coverage as a result of RAC findings that services were not medically necessary under the RAC demonstration project.

New NALTH Payment Policy Research: Medicare policy makers have historically questioned that Medicare payments made to short-term acute hospitals under the IPPS payment system may be duplicative of payments for services which are made to LTCHs under the LTCH-PPS. Concerns that the Medicare program overspends when Medicare beneficiaries are admitted from short-term acute hospitals to LTCHs have been advanced as a reason for adoption of the 25% rule. A primary goal of the 25% rule is to provide an incentive for LTCHs to restrict Medicare patient admissions from short-term acute hospital referral sources with the retention of these patients in short-term acute hospitals for a longer "full course" of hospital care. If CMS were to achieve this goal the short-term acute hospital length of stay would increase and more cases would become subject to the IPPS cost outlier policy. The IPPS outlier policy, like the LTCH-PPS cost outlier policy requires that the cost of a patient's care exceed PPS payment by 80% before a patient reaches cost outlier status. CMS has expressed concern that the admission of patients to LTCHs from short-term acute hospitals may avoid the IPPS cost outlier policy and result in losses to the Medicare program. CMS has also questioned that IPPS payments may be duplicative of payment for services and payments that are made to LTCHs. While stating these concerns, CMS has never presented an empirical basis for the fundamental conclusion that the Medicare program looses money and over spends when patients are discharged from short-term acute hospitals to LTCHs. NALTH decided to conduct an empirical analysis to test whether CMS's assumptions and concerns by assessing whether Medicare program expenditures are higher or lower, on an LTCH industry-wide basis, when Medicare patients are discharged to LTCHs as compared to Medicare expenditures which would have occurred if Medicare patients had remained in short-term acute care hospitals. In order to conduct this study NALTH received permission from CMS to use a patient identified all Medicare beneficiary version of the Medpar file which allowed for a tracking of patients from short-term acute hospitals to LTCHs and includes all Medicare patient specific and facility data reported on the UB-92 form.

NALTH's research involves two phases. The first phase was to assess whether LTCHs are payment efficient. NALTH analyzed on a net LTCH industry bases whether Medicare payments would have been more or less if patients had reminded in short-term acute hospitals and received the same services each patient received in thier short-term acute hospital and LTCH stays. In order to perform this analysis NALTH constructed a combined hospital stay for each of 106,000 patients who were admitted to LTCHs in 2005. All cases were recoded and, where applicable, a new MS-DRG was assigned in order to construct for each patient single extended short-term acute hospital stays which would have occurred in the absence of the admission of patients to LTCHs. In order calculate Medicare expenditures, NALTH updated patient costs and Medicare payments for each short-term acute hospital that made a referral to a LTCH and each LTCH who admitted these patients to account for Medicare updates and policy changes applicable in 2010. This analysis has been completed and shows that, on a net payment basis, Medicare payments would have been approximately $252 million higher in 2010, assuming the same patient case mix and volume as occurred in 2005, if Medicare beneficiaries were not admitted to LTCHs and had remained in short-term acute care hospitals. The underlying assumptions for this analysis are: 1) that in the absence of admission to a LTCH a patients length of stay in short-term acute hospitals would increase and be approximately the

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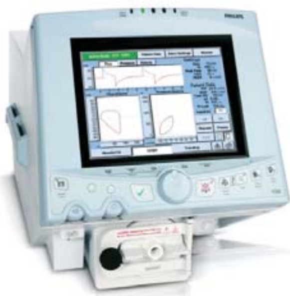

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NALTH Quality Achievement Award ...continued from page 4

appropriate skill levels necessary to respond. The committee members performed a retrospective chart audit of patients suffering from a cardiac or respiratory arrest to identify early signs of decline.

Develop

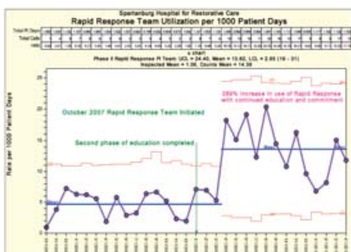
The committee identified the appropriate structure for the Rapid Response Team to include at a minimum, a critical care nurse and a respiratory therapist. Additional responders would include nursing supervisors, nurse practitioners, physician assistants and physicians. Next, the committee developed standard criteria for summoning the Rapid Response Team based on IHI guidelines and empowered staff to act on their intuition. Additionally, the committee developed an electronic documentation tool to record each rapid response event. This document was developed using the situation-background-assessment-recommendation (SBAR) communication strategy. The SBAR tool was implemented to facilitate the accurate transfer of patient assessment information in a clear, precise manner. The committee developed staff and physician education which included the purpose for the team, criteria for activation, roles and responsibilities of each team member, strategies for effective communication and proper documentation. As part of the education, a quick reference card was developed highlighting the fundamentals of the rapid response process.

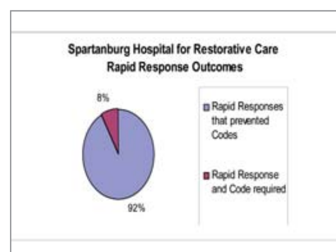
Execute/Evaluate

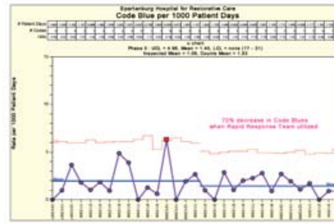
The Clinical Unit Educator and Respiratory Educator jointly provided mandatory education to the clinical staff. Nonclinical staff was provided education through our e-learning system. In October 2007, the Rapid Response Team was implemented. Since its deployment the Quality Department has collected monthly data in an on-going effort to analyze the progress of our Rapid Response Team. This information is presented to the Code Blue Rapid Response Committee, Performance Management Council, Medical Executive Committee and to the Board of Directors.

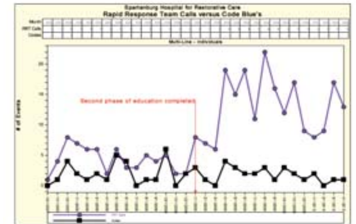
Results and Measurement Indicators

From October 2007 through April 2010, there were 273 Rapid Response Team calls with a 70% reduction in code blue alarms. This data supports that increased utilization of the Rapid Response Team has yielded a reverse relation resulting in the reduction of code blues. Specifically, 92% of Rapid Response Team calls did not result in cardiac or respiratory arrests. In April 2009 our Rapid Response Team utilization increased significantly (289%) and resulted in a positive special cause due to continued education and staff empowerment.









Clinical Implications

The major benefit of implementing a Rapid Response Team has been the reduction in the number of cardiac and respiratory arrests. Additional benefits reaped from this initiative include a change in culture resulting from the increased respect and communication among critical care nurses, medical surgical nurses, respiratory therapists and physicians; a greater sense of collaboration across the disciplines; and the improved assessment skills of the clinical staff as each rapid response activation presents a unique education opportunity.

Financial Impact

From October 2007 through April 2010, SHRC estimates a financial savings of $310,000 through the reduction of code blues.

Lessons Learned

Initially, the Rapid Response Team was underutilized due to staff apprehension in initiating calls. As a result, additional education was provided to re-emphasize that every call would be considered acceptable. Staff was encouraged and empowered to trust their intuition and to call a rapid response whenever they felt something just wasn't right with a patient.

The committee recognized the significant role patients and families play in ensuring the delivery of high-quality healthcare; thus, a process was established for them to activate the Rapid Response Team. On admission, patients and families are educated on the process for calling a Rapid Response. This information is also posted in each patient's room.

Conclusion

As a long-term acute care hospital, we treat patients with complex medical conditions who are at greater risk for cardiac or respiratory arrest. Our goal is to provide the best possible care to our patients and to prevent life-threatening situations. Based on our results, we are confident that the implementation of a Rapid Response Team is improving patient outcomes and saving lives.

References

Improving Early Recognition and Response to Patient Changes: Empowering staff to act quickly to prevent cardiac arrest [Electronic version]. Joint Commission Perspectives on Patient Safety. (August 2007, Vol.7, Issue 8).

Overview of the 100,000 Lives Campaign. (n.d.). Retrieved September 10, 2010, from http://www.ihi.org/IHI/Programs/Campaign/100kCampaignOverviewArchive.htm

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News from NALTH's Benchmarking System, NHIS

CMS and The Joint Commission "Tour" NHIS

Representatives from the CMS Office of Clinical Standards and Quality participated in a webinar demonstration of NHIS in July. CMS is looking to gain a better understanding of what information is critical and also feasible for long term care hospital's to collect for the health and safety of Medicare beneficiaries as a part of the Patient Protection and Affordable Care Act (PPACA).

Leadership from The Joint Commission also participated in a demonstration of NHIS in their efforts to develop quality measures for LTCHs.

"We have been very pleased to receive such a positive response to NHIS during these demonstrations and to be able to assist with these important initiatives" says Cheryl Burzynski, President of NALTH.

NHIS Survey – NALTH is seeking input from NHIS participants on future initiatives and priorities. Please be sure to respond to the survey – your input is important!

***Executive Summary Report** – Coming Soon* - Programming is now complete and the NHIS Executive Summary Report is in final testing. "It is a very complex report that draws from all different aspects of NHIS and has required a lot of back and forth with our programmers. We want to assure that all the calculations are correct before we release it. And we are almost there." says Jeannine Dollard. The Lewin Group expects to launch the report on NHIS by October 1st. This new report will be a helpful summary of key quality, financial and operations indicators in an easy-to-read summary format suitable for management and Board reporting.

New Look to ORYX Reports – NHIS ORYX Reports will soon have additional trending information and will include hospital percentile rankings for each Non-Core ORYX measure. These enhancements will be seen in Q3 2010 reports. We hope you find the new information helpful.

Welcome New NHIS Participants – We are pleased to welcome the following hospitals to NHIS!

Hospital	Location
Baptist Health Extended Care Hospital	Little Rock, Arkansas
Highsmith-Rainey Specialty Hospital	Fayetteville, North Carolina
St. Vincent Seton Specialty Hospital	Indianapolis, Indiana
St. Vincent Seton Specialty Hospital	Lafayette, Indiana
Hebrew Rehabilitation Hospital	Roslindale, Massachusetts

NALTH Health Information System, NHIS

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NHIS Contract Manager
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A CMS VALIDATION SURVEY: ONE HOSPITAL'S EXPERIENCE

New England Sinai Hospital

In March 2010, one and a half months after a late January Joint Commission survey, 14 members of the Massachusetts Department of Health paid an unannounced visit to New England Sinai Hospital, a long-term acute care hospital in Stoughton, Massachusetts. The DPH surveyors, authorized to conduct a CMS validation survey, spent 7 days at the hospital intensely scrutinizing every area of our care delivery system. The survey parameters were comprehensive and included our main campus, satellite locations and outpatient services. The team of surveyors interviewed members of senior leadership, management, and hospital staff, reviewed policy, protocols and procedures, examined life, safety issues, and most importantly carefully observed the delivery of patient care at the bedside. During their time at the hospital, the team of surveyors briefed senior leaders on a daily basis as to the survey's progress and their findings.

During the Joint Commission process in Jan 2010, the Accreditation Team made several recommendations for improvement related to competency assessment, environment of care, Infection Control, medical staff supervision, monitoring of contracted services, and clinical documentation. At the time of the CMS survey, hospital staff was in the process of developing, implementing and submitting a corrective action plan to the Joint Commission by April 2010.

What Prompted the Survey

The Joint Commission has been given "deemed" status to assess compliance with CMS' Conditions of Participation (CoP). As part of that process, CMS randomly conducts validation surveys for healthcare organizations following a full Joint Commission accreditation survey.

The Results

The rigorous survey process identified additional opportunities for improvement in organization structure, care delivery and oversight of care by the medical staff and the governing body. Surveyors primarily concentrated their observations on care delivery. They did not focus on criteria that is most often at the forefront of a board member's attention: quality decision making, review of benchmark data, ORYX measures and "dashboard" items.

It is important to note, that coincidentally, the hospital experienced and was investigating, two serious patient incidences during the survey. In accordance with survey protocols, the hospital notified the CMS team of these two events and reported the event to DPH. As expected, near simultaneous reporting of two incidents resulting in serous patient harm triggered an extensive examination of the reporting policies and procedures, and appropriately directed the attention and concern of the surveyors to our wound care, infection control and IV insertion policies and procedures.

Survey Team's Primary Concerns:

- direct patient care – observing patient and caregiver interaction at the bedside
- Medical oversight of patient care
- Gown and glove procedures with precaution patients
- IV insertions
- Wound care policies and practices

During their observations of care, team members fanned out through the hospital, frequently questioning nurses about their compliance with the CoP.s For staff unaccustomed to such vigorous oversight, this was at times a difficult and disconcerting experience.

What the Survey Found

The main areas of focus and those deemed to be seriously flawed, demanding immediate improvement to be in accord with CMS guidelines were: wound care; placement of intravenous lines; infection control practices; restraints; internal failure to report serious incidents in timely manner.

CMS uncovered a disconnect involving the medical staff's participation in skin assessment on an ongoing basis, and a failure of nursing practice to address this consistently. There was a failure to follow the hospital's IV policy and failure to properly document the use of antibiotics in a patient where an IV extravasation of the antibiotic, Vancomycin (extremely caustic to soft tissue and skin) caused necrosis in a patient's foot.

Some of the areas of concern as cited by the survey team were:

- Medical staff oversight of patient care, nursing care and pharmacy, infection control
- Alcohol based hand sanitizers and staff compliance
- Requirements for history and physical examination, authentication of verbal orders, and securing medications
- Restraint and seclusion in hospitals
- Sprinklers, smoke alarms (life safety code)

The survey report outlined expectations for leadership and board and emphasized that the responsibilities of the hospital's governing body extended to the safe implementation of care and oversight to ensure staff was 100% in compliance with all care criteria.

Immediate Jeopardy

There are different levels of CMS deficiencies, the most serious is Immediate Jeopardy, a situation that poses an immediate threat to the health and safety of patients identified during the survey. Our hospital received an Immediate Jeopardy finding, and was asked to voluntarily suspend new admissions while corrective actions were put into place. This punitive measure resulted in significant financial consequences for the institution.

Sinai's Response

Sinai's immediate response included:

- Development of action plans to address all issues
- Review and updating of all policies to be in complete compliance
- Education of staff in all areas improvement indicated
- Engagement of Leadership, Governance and the Medical Staff in the immediate development and implementation of action plans
- A deliberate and careful examination of board functions, as a result of CMS's position holding the governing body (the hospital's board) responsible for all activities in the organization and the compliance with CoP.

What can we learn from the survey experience?

Leadership and governance should be acutely aware of CoP areas, and be vigilant that they are carefully addressed and adhered to within the organization. This must be a constant and ongoing process and systems must be implemented and continually reviewed to ensure adherence to the highest standards of care. Board level oversight is critical to the delivery of care and the caring process and board education to this end is essential.

Prepare for Site Visits

The successful outcome of a site visit is a result of an organization's continuous involvement in improvement initiatives, and strict adherence to all compliance CoP. These are things that must be ongoing – ingrained in the hospital's culture. There are however, some things that can be done to help make the visit go smoothly and be less stressful for staff, the following might be considered:

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- Assign an internal escort to each member of the survey team – consider making this policy.
- Develop plan to address any situation in which staff is being treated overly aggressively.
- Create a document binder of all relevant policies, procedures, meeting minutes, and other relevant items
- Schedule regular debriefing meetings to advise management how the survey is going, to identify deficiencies that may be cited, and to respond with corrective actions even before they are identified by the survey team.
- Have a process in place that outlines the steps necessary in developing and implementing corrective action plans.

In Conclusion

While long term acute care hospitals have a history of excellent core measures, it is important that we do not become complacent. When 100% compliance is the expectation, it is essential to understand CoP and to continually monitor operations to ensure these are being met. Convening hospital leadership to review and discuss any potential risk issues following a Joint Commission survey, is a first step to weathering a validation survey successfully.

Health Reform Policy & Regulatory Update

...continued from page 5

same as the actual short-term acute hospital - LTCH combined length of stay; 2) that services, i.e. procedures, provided in a combined short-term acute hospital and LTCH episode of hospital care would be the same; 3) that the medical services provided in the LTCH and short-term acute hospital stays were medically necessary; and 4) use of the referral short-term acute hospital average cost as derived from hospital specific cost to charge ratios adequately estimates cost outlier payments which would have been made to each short-term acute hospital in the absence of discharge of patients to LTCHs.

The results of Phase I of this research shows that patients with relatively high case mix, or who had ICU or CCU use for a significant time in a short-term acute hospital or who were assigned a high number of procedures or secondary diagnoses, or who were cost outliers in a short-term acute hospital are likely to result in lower Medicare payments over an episode of care if they are discharged to a LTCH. NALTH has reviewed Phase I study results with the NALTH membership in a member webinar.

Phase II of the study involves the development of as predictive model to better identify, in advance of admission to a LTCH, patients who are likely to result in payment savings to the Medicare program if they receive services in a LTCH. Phase II also involves the development of payment policies that could implemented to replace the 25% rule. NALTH will continue to report to its membership on the progress of this study.

NALTH will review these study results with LTCH industry representatives, including ALTHA, the AHA and the Federation of Health Care Systems. NALTH will meet with CMS and Medpac to review the results of this study.

Establishment of LTCH Specific Quality Outcome Measures: NALTH has reported to its members in the past that health reform legislation requires the establishment of LTCH specific quality outcome measures by 2012. These quality measures will be used for mandatory industry reporting in 2014 and in payment pilot projects. NALTH has provided CMS, Medpac and the Joint Commission with webinar reviews of the NALTH National Health Information System (NHIS) . The NHIS collects data on quality and process measures as well as operational measures. The Joint Commission has expressed an interest in establishing quality measures for the LTCH industry. In early October, NALTH is scheduled to meet with the Joint Commission and ALTHA to discuss this important policy issue. Also in October MedPAC with convene a panel of LTCH industry representatives to discuss LTCH quality measures. NALTH expects that Medpac will report to CMS on its recommendations for LTCH quality measures.

New Requirements for Compliance with 25 Day ALOS Requirement: CMS has issued Change Request 6821 which requires MACs to include Medicare Part C (Medicare Advantage) days and related patient discharges in their determinations of LTCH compliance with the 25 day ALOS certification requirement. The Change Order follows on an earlier requirement which CMS has issued that all hospitals, and not just LTCHs, must report Part C patient day and discharge data. NALTH has recently clarified with CMS that use of Part C patient day and discharge data to determine LTCH compliance with the 25 day ALOS requirement is effective for LTCH cost reporting periods commencing on and after July 1, 2010.

Litigation News - Medical Necessity Review: At the last two NALTH annual meetings the NALTH membership has received reports on litigation involving the denial of 42 cases at the Spartenburg Restorative Care Hospital by a RAC during the RAC demonstration project. As of this time the hospital has achieved reversal of 39 of the 42 cases that were denied. At the 2010 annual meeting it was report that the Hospital was seeking payment of interest from the Medicare program for cases that it had won in the appeals process. CMS' position is that a hospital is only entitled to interest for time periods after that Hospital has prevailed at the Administrative Law Judge level of appeal, but only if not the hospital is not paid within 30 days of the decision by a ALJ. Notwithstanding CMS's policy the Hospital sought to have interest paid from the date of original recovery by the RAC. The hospital argued that the RAC had acted illegally in reviewed cases beyond a 4 year review period in the RAC scope of work and had otherwise violated laws against recoupment. Based on these arguments the Hospital requested that it be allowed interest from the original dates of recovery of funds. An administrative law judge has ruled in favor of the Hospital. CMS appealed from the ALJ decision to the Medicare Appeals Council. Medicare Appeals Council has found in favor of the Hospital and against CMS. The Hospital will now receive interest at over 10% on amounts recovered do to erroneous RAC denials. The Hospital was represented by NALTH's General Counsel's law firm.

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New Medicare Program for Medical Equipment Will Change Everything

The Centers for Medicare and Medicaid Services (CMS) will be implementing a new program January 1, 2011 that will change how Medicare beneficiaries and their referral sources can obtain medical equipment. Presently Medicare beneficiaries and referral sources are allowed to choose a medical equipment supplier of their choice. The new program called "competitive bidding" will reduce the choices for beneficiaries and referral sources.

CMS has contracted with a limited number of medical equipment suppliers in 9 competitive bid areas (CBA's) across the United States. Medicare Beneficiaries living in those 9 CBA's will be required to use a medical equipment company from the approved list of contracted suppliers to receive certain pieces of Medical Equipment. The list of the products and the nine areas affected are below:

The Products included in the competitive bidding program

- Oxygen Equipment & Supplies
- Standard Power Wheelchairs, Scooters, and Related Accessories
- Complex Rehabilitative Power Wheelchairs and Related Accessories-(Certain products)
- Mail-Order Replacement Diabetic Supplies- Mail Order Only
- Enteral Nutrients, Equipment and Supplies
- CPAP, RADS, and Related Supplies and Accessories
- Hospital Beds and Related Accessories
- Walkers and Related Accessories
- Support Surfaces (Group 2 mattresses and overlays) in Miami Only

The Nine Competitive Bid Areas starting January 1, 2011

- Cincinnati-Middletown (Ohio, Kentucky and Indiana)
- Cleveland-Elyria-Mentor (Ohio)
- Charlotte-Gastonia-Concord (North Carolina and South Carolina)
- Dallas-Fort Worth-Arlington (Texas)
- Kansas City (Missouri and Kansas)
- Miami-Fort Lauderdale-Pompano Beach (Florida)
- Orlando (Florida)
- Pittsburgh (Pennsylvania)
- Riverside-San Bernardino-Ontario (California)

The complete county listing for all 9 CBA's can be found at www.medicaresuppliersnetwork.com.

How will this affect Referral sources and Medicare beneficiaries?

This will affect you (the referral source) and your Medicare beneficiary in numerous ways.

1. If a patient needs one of the products listed above, and resides in one of the CBA's they are required to get the products from a Medicare contracted supplier for that area.
2. If a patient currently uses one of the products above, and the patient resides in one of the CBA's listed above, they may be required to change providers, to a Medicare contracted supplier. (Some exceptions are allowed, see www.medicaresuppliersnetwork.com for the list of exceptions)
3. If a patient resides in one of the CBA's listed above, they may only continue using their preferred medical equipment supplier if the supplier won the product category for that CBA.
4. You may be required to use multiple suppliers for different products to fulfill your patient's needs.

The list of approved contracted medical equipment suppliers will not be released by CMS until September 2010. The list will include the name and contact information for the medical equipment companies that are contracted for each competitive bid area (CBA) and each product category.

We realize that this sounds confusing and you may have a lot of questions about the program and how it will affect you or your patients. A website has been created to help educate both the Medicare beneficiary and all referral sources. This website is educational only. www.medicaresuppliersnetwork.com will answer any questions you may have. We will also be providing additional information as soon as it is released by CMS. You may also email us at info@medicaresuppliersnetwork.com to answer any questions you may have.

Note- The competitive bidding program only applies to Medicare patients residing in the 9 areas that are in need or are using the products listed above and begins January 1, 2011. If your patient resides outside of the 9 areas listed above or they are not on Medicare then the process for obtaining medical equipment remains the same as today.

NALTH Repository of Medical Necessity Review Appeals Data

NALTH thanks those members who have submitted data to the repository and encourages other members to participate. Providing data to the repository is voluntary and all data remains confidential (i.e., an overview of the data, but not any specific data, is available to NALTH's Medical Necessity Review Committee and its General Counsel, and may be made available to its Members from time to time). Participating in the repository provides NALTH and it's members the opportunity to maintain a pulse on the regulatory reviews and is vital in assisting NALTH in making policy decisions.

To date, 25 NALTH member hospitals have submitted data. The repository will be overviewed during a NALTH Annual Meeting. For more information, please contact Patricia Stimac of Spartanburg Hospital for Restorative Care at pstimac@srhs.com.

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2010/11 NALTH BOARD OF DIRECTORS

Please welcome the new NALTH Board of Directors elected by the membership during the NALTH Annual Meeting held April 29 and 30, 2010 in Washington DC:

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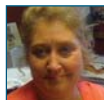

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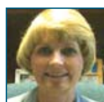

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NALTH | Educational Meetings & Conferences

NALTH offers premier educational events for LTCH associated professional staff committed to advancing the health, well-being and quality of care for medically complex patients who require prolonged hospital stays.

Educational events not only offer a forum to discuss industry and patient issues, but also promotes high levels of interaction and networking among LTCH professionals.

NALTH 22ND ANNUAL MEETING

The Future of Long Term Care Hospitals (LTCHs)

Thursday, April 28 – Friday, April 29, 2011

Omni Shoreham Hotel • Washington, D.C.

- Transforming Outcomes Data into Management Information
- Medical Necessity Review Policy
- LTCH Industry Sponsored Research
- NALTH Repository of Medical Necessity Review and Appeals Database
- Congressional Health Staff
- Goldberg Innovation Award Winner Presentation
- Health Reform Policy and Regulatory Update
- NALTH Member Business Meeting & Election of Officers

NALTH 2011 Educational Conference

October 6-7, 2011

Omni Royal Orleans Hotel, New Orleans, LA