NALTH Members,

I believe the first order of business is to thank you, the NALTH membership, for entrusting the role of NALTH’s Presidency to me again for the next two years. I hope that I can use my past experience to assist NALTH as the association dedicated to long term care hospitals. Health care in general is uncertain and in flux - and without a voice representing our small industry we could easily be overlooked and impacted by larger health care providers and their business plans. During my past presidency in 2011/2012, the industry was facing the issues from the 25% rule, the moratorium, scrutiny and proposed reimbursement changes, lack of LTCH facility criteria and actual acknowledgement of what LTCHs do and how they "fit" within the post acute care system.

Although the Board of Directors remains strong and working diligently for the members, the NALTH professional team has undergone significant changes in the past eighteen months. The NALTH professional team is available to support NALTH members and the Board during continued industry challenges. The NALTH professional team:

GENERAL COUNSEL - Rochelle H. Zapol,
Prince Lobel Tye LLP, Boston, MA
rzapol@PrinceLobel.com

DIRECTOR - POLICY & RESEARCH - Lane Koenig, PhD
KNG Health Consulting, Rockville, MD
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LEGISLATIVE CONSULTANT - Jon Sheiner
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ADMINISTRATIVE DIRECTOR - Ryan Dryden
rdryden@nalth.org

As an active NALTH Board Member since 1996, I have assisted NALTH with many projects and the Board has focused on issues as identified by our members. NALTH has a diverse membership, which includes not only many small, less than 50 bed hospitals and satellites, but also large LTCH chains - we represent both for profit and not for profit LTCH members.

As President, I see the following as critical Association priorities: analysis of rule changes and reimbursement developments, support of issues through advocacy and legislation.

NALTH is the only association that represents "just the LTCH industry". We pride ourselves in our uniqueness and our positive reputation on Capitol Hill and with CMS. We have a consistent approach to regulatory proposals where we use empirical research and analysis to understand proposed rules and their impact on the industry. We use our research data to effectively communicate how regulatory changes will affect our members, and we share our findings with CMS, MedPAC, Legislators and others.

NALTH’s focus will remain research, advocacy and being able to guide our members in difficult times as policy changes and reimbursement will be rapidly changing. Your NALTH Board has made it a priority to ask for more member involvement in NALTH committees and advocacy. We are improving our communication through monthly updates, member calls and more timely advisories. Please feel free to contact Board members for input and guidance – contact information is in this newsletter. As President, I welcome your questions and comments – and I will make it a priority to assist you or guide you in the best direction for your needs. NALTH listens to its members, so please share your ideas and participate in member calls, surveys, committees and calls for advocacy. The members are NALTH’s future.

In summary, this is a time of change, and I am here as your Association’s President to represent you to the best of my ability. I wish to hear from you, get your ideas and encourage all of you to be advocates of NALTH as we proceed into our 26th year. I hope to represent you well and I will look forward to your assistance and guidance.

Respectfully,

Cheri Burzynski, MSN, RN, BC-NE
NALTH President
The LTCH Community Faces Significant Changes Over the Next Several Years - If Its Members are to Thrive, They Must Engage in the Process

We are in the midst of great change in the delivery and financing of health care in America. The Affordable Care Act (ACA) and the extraordinary increase in the number of insured Americans both through private coverage and Medicaid will lead to the greater utilization of health care providers of all levels. The baby boomer generation means that the number of people covered by Medicare will grow faster than ever since the program's inception nearly 50 years ago. At the same time as this growth in Medicare covered lives, we will likely see a growth in the market penetration of Medicare Advantage especially if retirement income of the baby boomers is insufficient to support Medicare policies.

The ACA has also increased the efforts to find efficiencies in health care spending through new methods of organization and reimbursement. The movement to make the delivery of health care more efficient will be ever present.

Along side these important trends have been the most significant changes in the Medicare reimbursement of LTCHs since LTCHs began to be reimbursed under the prospective payment system. Last December's Pathway for SGR Reform Act dramatically altered the Medicare payments for LTCHs. The decision to reimburse at the LTCH level of payment only for cases that had spent at least three days in short term acute care hospital ICUs or have had 96 hours of ventilation therapy reflects Congressional acceptance of the argument that LTCH level reimbursement should be limited to only those cases of acute inpatient need. While some provisions of the Medicare LTCH reimbursement regime were liberalized along side the new limitations, including changes in the calculation of the 25 day average length of stay requirement and the extension of the moratorium on the 25% rule, the overall impact is estimated to be a reduction of about $3 billion in reimbursement to LTCHs over the next ten years.

Even after these significant changes, more change is inevitable. Members of Congress are more concerned than ever about the annual $70 billion plus spent on post acute care. They take note of the several different post acute care providers each with a distinct reimbursement model, but with overlapping elements of care. They see varying levels of profit margins within and between each set of providers. They see inefficiencies and fraud. Their response has been to seek greater rationality and efficiency in reimbursing for post acute care. The solutions most frequently expressed are site neutral payments tied to the patient and the condition rather than to the type provider and bundled payments placing the responsibility and risk in one entity to manage post acute care.

While these changes are not immediately imminent, Congress has begun work on laying a foundation for change. A bi-cameral/bi-partisan effort has developed the IMPACT bill. This bill is designed to develop a data base to inform and support change.

In the meanwhile, the largest for profit LTCH providers are moving in parallel with the regulatory changes to be able to offer bundled packages of care from the most acute in LTCHs to the less intense home health.

If NALTH members are to thrive in this emerging environment, they must be engaged in the policy development process. Members of Congress, their staffs and the staff of the Administration are almost always earnest and well meaning. But, their decisions can only be made in the context of their knowledge. It is incumbent on NALTH members to educate their representatives in Congress.

We have seen where NALTH members have engaged their representatives in Congress, the response has been positive. Members of Congress like Ways & Means Committee Chairman Dave Camp, Connecticut Senator Chris Murphy, and Nebraska Congressman Jeff Fortenberry have all responded favorably to the message of their NALTH members once they have witnessed and learned about the important roles that LTCHs play in their communities.

NALTH members need to broaden this effort to as many Members of Congress as possible. One of the most effective means is to invite your Representatives and Senators and their staffs to your facilities and to the facilities of your parent organizations where your facility is part of a larger organization. When you have this opportunity, you can provide a dramatic presentation of the importance of your LTCH.

Another means is to use your trustees and executives. Often your trustees are leaders in the community in more than one context. Many have relationships with political leaders in the community, including Members of Congress. Ask these men and women to reach out to their political contacts to bring legislators to the LTCH.

More than likely, your LTCH employs several highly skilled professionals and spends a significant amount of money in the community. More than likely it enables the community’s acute care hospitals to operate more efficiently. You need to make political leaders aware of the important role your LTCH plays in the community.

The data that has been collected and studied by NALTH shows there are financial savings and health benefits for a significant number of cases discharged from short-term acute care hospitals. Putting this data together with a real time demonstration of what your LTCH does can be a powerful message.

If you have any questions about how to reach out to your representatives in Congress and how to approach them, please contact Jon Scheiner at jon.sheiner@verizon.net.
Policy, Research, and Legislative Update

NALTH is working on developing its policy, research, and legislative agenda for the rest of the year. Two high priority areas are addressing unresolved issues related to the Pathway for SGR Reform Act and the omission of wound cases in the new LTCH criteria. Both will require a strong response to the FY 2015 IPPS-LTCH proposed rule and advocating for changes with policymakers in Congress.

Policy
On April 30, 2014, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule for fiscal year (FY) 2015 regulatory updates for the Inpatient Prospective Payment System (IPPS) and the Long Term Care Hospital Prospective Payment System (LTCH-PPS). The rule was published in the Federal Register on May 15, 2014 and comments are due by June 30, 2014. NALTH will be submitting comments to the proposed rule, as it does every year.

Although the rule includes details on several important policy updates, there was limited clarification for how CMS will approach LTCH-related policy changes required under the Pathway for SGR Reform Act of 2013. We describe open questions and issues related to implementation of the provisions in the Pathway for SGR Reform Act in Table 1 (Page 4). Some key points from the table include:

- CMS asked for comments on the development of LTC-MS-DRG weights and outlier threshold under the reforms to be phased in starting in FY 2016.
- NALTH remains concerned about CMS limiting the revenue center codes to be used to identify cases meeting criteria because of an ICU stay. CMS did not address this issue in the proposed rule.
- The current short-stay outlier policy is complex, distorts incentives for discharging patients at an appropriate time, and is unnecessary under the new criteria. NALTH is considering alternatives to propose to CMS.

Research
The exclusion of wound cases from the new criteria is of significant concern to NALTH and its members. Severe wound cases treated in LTCHs require services and special care not typically available in other settings. These services may include:

- Care by a multi-disciplinary team composed of: Physicians, Dieticians, Certified Wound Care personnel and Pharmacists.
- Pressure redistribution bed
- Negative pressure assisted vacuum closure device
- Surgical interventions, including skin graft and debridement
- Poly pharmacy
- Exudate management

LTCHs often lose money on severe wound cases under current LTCH PPS, but the need for prolonged hospital level of care makes LTCH placement the most appropriate. NALTH is concerned that beneficiary access to high-quality wound care may be limited under the new criteria.

To have any traction on the wound issue with policy makers, NALTH is working to answers three important questions:

1. Characteristics of patients: What distinguishes wound cases appropriate for LTCHs from other types of wound cases?
2. Resource need and availability: Are the resources and programs needed to treat these types of wound cases available in skilled nursing facilities or other non-LTCH settings? Why or why not?
3. Outcomes: Do wound patients who receive LTCH-level of care have better outcomes when treated in LTCHs as compared to other settings?

As a first step, the NALTH Quality and Research Committee is working to identify data sources that will help answer these questions, as claims data are insufficient because it lacks detail regarding severity. To this end, the NALTH Quality and Research Committee members are reaching out to companies that work with LTCHs and others in the management of wound cases. If you would like to help, please contact Lane Koenig (lane.koenig@knghealth.com) to share ideas, such as potential data sources to inform the questions above.

Advocacy
Once CMS releases the final rule, NALTH anticipates meeting with leadership at CMS and representatives in Congress to share our concerns on any unresolved issues as well as data and findings to support the inclusion of wounds in the new LTCH criteria. The nature of those meetings will depend on how CMS responds to NALTH’s comments in the final rule and our progress on addressing the questions concerning patients with severe wounds. Updates will be provided to NALTH members on our regular member calls.

...continued on page 4
NALTH WOUND STUDY

As you all know, wound care is a significant component of our expertise at LTCHs and NALTH has many members for which wound care is a major admission category.

NALTH endeavored to do a wound care outcome study about 12 years ago. However, due to the inconsistency in staging wounds throughout all of the healthcare venues it was seen as a daunting task, and therefore, was not pursued.

At the present time it is clear that the industry needs to prove its value in treating this difficult patient population. It is also true that there are many more certified wound care experts now than 12 years ago making consistency in wound care staging a realistic possibility thus leading to a better ability to track outcomes.

We have been approached by proprietary companies which state they have robust databases on wound outcomes which we will research to determine if they could be helpful in developing a multi-center outcomes study with NALTH. In addition, NALTH is considering other studies that may be completed in the short- to intermediate-term to help demonstrate the role and value of LTCHs in treating severe wound cases.

If any NALTH member would be interested in being involved with this possible research project please contact Ryan Dryden at rdryden@nalth.org
Description of Program/Process

Leadership and employee team huddles in hospitals have historically been used to keep staff members updated on staffing for the current and next shift. At Bethesda Hospital (member, HealthEast Care System), a new system CEO introduced the concept of a frontline management system that engaged all employees within all disciplines (physicians, nurses, therapists, non-clinical staff, etc.) as problem solvers using Lean methodology and Standard Work. This allowed us to take huddles to the next level and use them for something that may be a first in the LTACH industry: intentional transparency of quality in key metrics to improve patient safety and support an evidence-based care delivery system.

Lean is a process management system specifically aimed at improving workflow by eliminating or reducing waste; simplifying the system and processes to create continuous flow; and increasing value in the eyes of the customer. Standard Work is the current best, easiest, safest way to do a task and includes steps that are always done, providing the basis for continuous improvement. Prior to 2013, one would not have found regularly scheduled department/unit huddles on a daily basis throughout the hospital. There were regularly scheduled, house wide huddles for leaders only, but they primarily had an administrative focus. Finally, there was not a system in place that focused on improvement work from the perspective of staff members and patients. However, in 2013, daily, house wide, frontline huddles became common practice within our organization. One example is in nursing, where huddles are conducted daily on all three shifts and on every unit. These huddles are consistent practices that have had an intentional, positive impact on quality metrics. A total of 200+ nurses have worked as frontline problem solvers in these daily huddles. Improvement boards track unit metrics and host new ideas; Standard Work tools support these efforts. The huddles—and the use of specific tools—have resulted in significant improvements in two key quality metrics: falls and hospital-acquired pressure ulcers (HAPUs). Measurement indicators are provided in Section 4 and a results graph is attached. Samples of Standard Work tools are also attached.

From a process standpoint, our frontline huddles and use of Lean/Standard Work brought forth interdisciplinary opportunities to change the management of pressure ulcer and falls prevention. There is also a clear link and cascading of information bi-directionally from the senior executives to the frontlines regarding organizational strategies and key priorities and from the frontlines to the senior executives regarding metrics, hot spots and key countermeasures being applied at the bedside. Specific to pressure ulcer prevention, we now:

► have visual control and run charts at senior executive weekly huddles to review trends and countermeasures around our HAPUs and falls
► provide just-in-time review by our Patient Care Executive, Clinical Director/Manager, RN, NA, WOC APRN and other staff at the time any HAPU is identified
► offer concurrent reporting of all HAPUs at hospital-wide huddles two times a day
► offer increased frequency, scope and team involvement related to risk assessments
► focus on interventions to protect skin and document abnormal inspections
► utilize new methods in teaming and turning, lifting, devices, equipment and documentation
► utilize a refusal algorithm with non-compliant patients (see attached)
► provide a Rook boot algorithm, a house wide report form for charge-to-charge handovers, a staff RN report template on care plans and RN to NA and NA to NA handover template This improvement work, a direct result of frontline huddles, led to Bethesda being invited by the Minnesota Hospital Association to present a statewide webinar on tissue integrity and a feature story about our pressure ulcer prevention success being highlighted in this year’s Adverse Health Events Report. See page 19 of http://www.health.state.mn.us/patientsafety/ae/2014/ahereport.pdf. In the area of falls prevention, use of frontline huddles, along with the improvement boards and a Standard Work commitment, led to a reduction in patient falls. This process showed us that our bed frame and mattress combinations were not standardized, nor were the different practices in addressing patients’ unique needs. We assessed the patient population on each unit and assigned each patient care unit a primary bed frame and mattress type with the intention to reduce cognitive errors. This meant that the minimum standard interventions the nurses and aides used would be easier to implement because of standardized beds. A review of the standardization was completed, leading to the purchase of new bed frames and mattresses. As a result, we have experienced a decrease in the number of patient falls over the past nine months and rates have consistently been less than goal. Measurement indicators are provided in Section 4 and a results graph is attached. Both sets of improvement work, generated at our frontline huddles and supported by Lean/Standard Work, were the focus of a poster presentation that Linda Barnhart, our Patient Care Executive, delivered at the 2014 AONE (American Organization of Nurse Executives) annual conference. See attached. The Standard Work template used at huddles shows how we accomplish our goals. See attached.

Uniqueness
From an internal perspective, this initiative is one of only a small number of initiatives that meet all four of our organization’s strategic pillars: clinical quality outcomes, employee and physician engagement, patient experience and operational effectiveness and efficiency. From an external perspective, using Lean, Standard Work and a “bottom up” focus within a highly transparent, house wide, formalized frontline improvement system to drive work that improves clinical quality outcomes and financial performance is not an approach we believe is used at other LTACHs.

Measurement indicators
Since the introduction of the frontline huddles, utilization of Lean/Standard Work principles and increased transparency of quality information, there has been a significant reduction in HAPUs resulting in sustained improvement of the HAPU rate. We have moved from 5.3 to 2.3 percent of our patients having a HAPU during our monthly incidence studies (a 53 percent decrease). In addition, a significant reduction in our falls rate occurred starting in March 2013 with a sustained improvement (10 out of 12 months below target) from 2.9 to 1.7 falls per 1,000...continued on page 6
patient days, reflecting a 41 percent de-
crease. See attached for reporting period in-
formation.

Section 5: Financial impact
Bethesda used a 2009 CMS-provided equa-
tion for calculating the cost related to HAPUs
(both in terms of treatment and re-hospital-
ization). We realized a 47 percent reduction
in our Stage 1 and 2 HAPUs, from 17 in fis-
cal year 2012 to 9 in fiscal year 2013. Eight
fewer occurrences at an approximate cost of
$3,705 per occurrence equaled $29,640 in
savings. In addition, HAPU reportable events
(Stage 3, 4 and unstageable) declined 56
percent, from 9 in fiscal year 2012 to
4 in fiscal year 2013. Five fewer occurrences
at an approximate cost of $43,180 per occur-
rence equaled $215,900. Combined savings
to Bethesda Hospital in the area of pressure
ulcer improvement due to the efforts of the
frontline management system using Lean
and Standard Work totaled $245,540. In the
area of falls prevention, Bethesda used a
2011 CDC-provided equation for calculating
related costs (both in terms of treatment and
re-hospitalization). We realized a 15 percent
reduction in overall falls, from 33 in fiscal
year 2012 to 28 in fiscal year 2013. Five
fewer occurrences at an approximate cost of
$19,440 per occurrence equaled $97,200 in
savings. Additionally, we reduced our re-
portable falls (those with injury or death) 100
percent from 1 in fiscal year 2012 to 0 in fis-
cal year 2013, for a savings of $35,000.
Combined savings to Bethesda Hospital in
the area of falls improvement due to the ef-
forts of the frontline management system
using Lean and Standard Work totaled
$132,200. Total potential savings: $377,740

Section 6: Lessons learned
In addition to achieving sustained clinical
quality and financial performance improve-
ment, enhancing patient safety and bolster-
ing an environment rooted in
evidence-based care delivery, we found that
developing highly transparent, regularly
scheduled, house wide frontline huddles that
embrace Lean and Standard Work brought
other benefits including:
► supporting open, two-way communica-
tion that quickly addresses issues of op-
portunity
► engaging and empowering staff to help
make decisions based on frontline
experiences
► reducing the risk of system or process
failure
► instilling the organization’s mission, vision
and values
► identifying obstacles and resolving
challenges in a timely manner
► reducing interruptions during the rest of
the day
► notifying all participants of team/individ-
ual work status
► encouraging teamwork so that all co-work-
ers are on the same page
► hardwiring a standardized “reflection”
process whereby teams and leaders can
centrally capture best practices and spread
them throughout the organization
► creating a transparent connection between
senior executive strategies and work to
ideas at the bedside, leading to greater
alignment

This process could be replicated at other
locations that possess: frontline staff open
and willing to incorporate a new process for
creating a culture of improvement; interdisci-
plinary and senior executive leaders
who are passionate and highly engaged
around this type of cultural change; a com-
mitment to using data to drive continuous
process improvement; and a spirit of ac-
countability. Thank you for the opportunity
to present this transformational process to
the NALTH community.
Improvements in HAPUs and Falls

March 28, 2014

THIS CONTROL CHART PROVIDES EVIDENCE THAT A SIGNIFICANT REDUCTION IN HAPU OCCURRED STARTING MAY 2012 RESULTING IN SUSTAINED IMPROVEMENT OF THE HAPU RATE FROM 5.3 TO 2.3

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Standard Work: Bethesda Visual Control Room Huddle Report – HAPUs and Falls

<table>
<thead>
<tr>
<th>Step</th>
<th>WHO</th>
<th>WHAT</th>
<th>HOW</th>
<th>WHY</th>
<th>Reason for step</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Huddle Leader</td>
<td>Review the list of patients who are at risk of developing a pressure ulcer for accuracy and completeness.</td>
<td>Highlight any errors, using the patient’s room number. Include a list of patients who are high risk for developing skin breakdown.</td>
<td>To alert the Charge Nurse who needs to plan to prevent skin breakdown.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Huddle Leader</td>
<td>Review the list of HAPUs and ask the Charge Nurse (by unit) for an update on the status of the HAPU.</td>
<td>Include notes about the current risk, level of care, and plan to prevent skin breakdown.</td>
<td>To ensure accountability for the patient’s skin integrity.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Huddle Leader</td>
<td>Review the list of patients who are at risk of falling for accuracy and completeness.</td>
<td>Update the list with new falls and add the patient’s skin integrity to the list.</td>
<td>To alert the Charge Nurse of the patient’s current risk.</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Huddle Leader</td>
<td>Review the list of patients who are at risk of falling for accuracy and completeness.</td>
<td>Update the list with new falls and add the patient’s skin integrity to the list.</td>
<td>To alert the Charge Nurse of the patient’s current risk.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Huddle Leader</td>
<td>Review the list of patients who are at risk of falling for accuracy and completeness.</td>
<td>Update the list with new falls and add the patient’s skin integrity to the list.</td>
<td>To alert the Charge Nurse of the patient’s current risk.</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Huddle Leader</td>
<td>Report restraint utilization percentage and ask Charge Nurse for updates/issues.</td>
<td>Update the list with new falls and add the patient’s skin integrity to the list.</td>
<td>To alert the Charge Nurse of the patient’s current risk.</td>
<td></td>
</tr>
</tbody>
</table>

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Bethesda Hospital Patient Refusal Repositioning and/or Heel Offloading Algorithm

<table>
<thead>
<tr>
<th>Step</th>
<th>WHAT</th>
<th>HOW</th>
<th>WHY</th>
<th>Reason for step</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Determine education barriers and document them.</td>
<td>Identify and address the reason the patient is refusing.</td>
<td>Does the patient now agree?</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Is patient displaying physically aggressive behavior?</td>
<td>Reposition patient and offload heels. Document in EMR.</td>
<td>Does patient now agree?</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Further assess for possible sources of refusal.</td>
<td>Reposition patient and offload heels. Document in EMR.</td>
<td>Does patient now agree?</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Staff RN informs Charge RN for Charge RN to approach patient.</td>
<td>Reposition patient and offload heels. Document in EMR.</td>
<td>Does patient now agree?</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Contact Director of Unit.</td>
<td>Reposition patient and offload heels. Document in EMR.</td>
<td>Does patient now agree?</td>
<td></td>
</tr>
</tbody>
</table>

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...continued on page 8
PROBLEM

Bethesda Hospital, member, HealthEast Care System, is one of the largest freestanding, not-for-profit, long-term acute care specialty hospitals in the nation. With an average daily census of 300 and average length of stay of 28 days, Bethesda cares for highly medically complex patients who have experienced a traumatic life-changing injury or event.

In 2012 there was an upward trend both in quarterly hospital-acquired pressure ulcer (HAPU) incidence rate and reportable events that fall under the Minnesota Adverse Health Events Reporting Law. In 2013, the hospital set a goal to reduce HAPU incidences from 6.1% to below 4.88% and reduce reportable pressure ulcer and falls with injury. In addition, a goal was set to reduce falls from 6.5 per 1000 patient days to 3.95 per 1000 patient days.

INTRODUCTION

In November 2013 we implemented LEAN improvement methodology: Value Based Improvement (VBI). This frontline improvement approach creates a culture of improvement by unleashing the shared creativity, knowledge, and problem solving abilities of frontline staff to create value from the patient’s perspective.

METHODS

Staff: Submit an idea improvement card structured with Plan, Do, Check, Act (PDCA) thinking.

LEADER

Plan, Do, Check, Act with the frontline staff who know the problem the best.

- Grasp the current situation
- Observe and identify the harm/waste
- Speak with data
- Identify the root cause

Some of the improvement efforts:

- Pressure ulcer and falls huddles
- Process maps
- Concurrent review of every pressure ulcer and fall by frontline staff, manager, director, wound APRN and CNO
- Repositioning refusal standard work
- Falls mattresses and beds standardization
- Twice daily charge nurse huddles
- All staff huddles every shift to ensure standard work for proactive risk assessment

RESULTS

We made dramatic positive impact on the Clinical Quality theme, “HealthEast is the Safest Place to Receive Care” by reducing reportable pressure ulcers from one occurring every 6 weeks to NO reportable event for 5 months.

HAPU incidence reduced from 6.1% to 2.64%

Falls have dropped from 6.5/1000 patient days to 3.7, with no reportable fall this fiscal year.

CONCLUSION/DISCUSSION

After 7 months we have experienced a significant process change and improvement (over 50%) in our quality outcomes by unleashing the potential of frontline staff. Using VBI improvement methodology has changed how we create value each day. We have created a culture of every employee as a problem solver.

REFERENCES:

HealthEast Care System Infonet: About HealthEast – Value Based Improvement

FOOTNOTE:

Reportable event pressure ulcer – Stage 3, 4, or unstageable ulcers acquired after admission to a facility, excluding progression from stage 2 to stage 3 if stage 2 was recognized upon admission.

Reportable fall – Patient death or serious injury associated with a fall while being cared for in a facility.
Healthcare-associated infections (HAIs) in acute care hospitals have long imposed significant financial strains on the nation’s healthcare system (Scott, 2009). Likewise, Long Term Acute Care Hospitals (LTACHs) are realizing the burden of HAIs. Urinary Tract Infections (UTIs) are the most common type of healthcare-associated infection reported to the National Healthcare Safety Network (NHSN). Among UTIs acquired in the hospital, approximately 75% are associated with a urinary catheter. Between 15-25% of hospitalized patients receive urinary catheters during their inpatient stay. The estimated cost per year for CAUTIs is $565 million, and the estimated number of deaths per year is 8,205 (National Healthcare Safety Network, 2013). The vast majority of CAUTIs are preventable. The most common and most preventable risk factor for developing a CAUTI is prolonged use of the urinary catheter. Because of the high frequency of catheter use in hospitalized patients, the burden of CAUTIs is substantial. Unique to acute care hospitals, Long Term Acute Care Hospitals (LTACHs) inherit a majority of patients, so to speak, with urinary catheters already in place when transferred to the facility.

Continuing Care Hospital (CCH) is a licensed 57-bed LTACH located in Lexington, Kentucky. Similar to other LTACHs, CCH found prevalence of indwelling catheters on admission to the hospital was 66% in 2008. CCH further found as a result of focused review of each patient’s need for an indwelling urinary catheter that of the 66% nearly 40% were found to be unnecessary. Infections associated with indwelling urinary catheters are common, costly, and morbid and more than two-thirds of the catheters utilized are not clinically indicated.

As found in the American Journal of Medicine, physicians are commonly unaware that their patients have an indwelling urinary catheter. Inappropriate catheters are more often “forgotten” than appropriate ones (Saints, et al., 2000). Additionally, many health care providers prefer to use an indwelling catheter because it is more convenient. A urinary catheter can give exact urine output, whereas incontinent patients output is less accurate. Additionally, nursing staff workload is reduced when the urine is collected in a device instead of in linens and adult briefs. Many healthcare providers feel a urinary catheter must be warranted to prevent skin erosion, even when there are no documented skin integrity issues. While a urinary catheter does have some benefit - protects the skin from urine exposure, provides output more accurately, decreases workload of nursing staff, risk and benefits need to be closely reviewed before the decision is made to keep the catheter. This all was true of the patient population of CCH. Significant culture bias needed to be changed to move the dot. An immediate call to action was initiated.

Implementation Plan

Don Berwick has famously said, “Every system is perfectly designed to achieve the results it gets” (2014). In order to achieve a decrease in CAUTIs, system-wide interventions aimed at discontinuing unnecessary catheterization were implemented for CCH using a multi-tiered approach.

- CCH internal CAUTI team was implemented led by the Quality Director and Hospital Epidemiologist. Nurse "CAUTI" champions were identified for every unit. Unit champions were educated on the project and lead weekly auditing of indwelling urinary catheters. Unit champions were trained on conversing with physicians when reviewing current patients with catheters. Weekly audits were submitted directly to the Director of Quality. Impromptu "CAUTI" rounds were conducted with the Hospital Epidemiologist, CAUTI champions and the Director of Quality. Charge nurses were educated on the project as well and submitted nightly indwelling catheter counts to the Director of Quality via fax/ email.

- A Urinary Catheter Removal Standing Order for Nursing Admission Review was implemented on admission to the hospital - the first in Kentucky. Removal of the indwelling catheter was recommended if the patient did not have a documented history of urinary retention, bladder irrigation, urinary tract obstruction, urologic surgery/ nephrology/ or urology consult, incontinence of management in a patient with stage 3 or 4 pressure ulcers or neurogenic bladder. A physician order is then obtained to remove the catheter if none of the criteria was met.

- Daily Foley Catheter Removal Standing Order was also implemented requiring a daily physician order for keeping the catheter in place. Nursing staff place the order in the chart for the physician to keep the current catheter. This was approved by the Medical Executive team. Key physicians were educated on the process.

- Evidence-based catheter bundle was incorporated in the policies, documentation, auditing and education. Education of indwelling urinary catheter necessity and alternatives for indwelling urinary catheters completed on 100% of nursing staff. Education was done in various avenues including online modules, poster presentation and education fairs. Policies were edited to reflect evidence based guidelines. Additionally, securement devices where purchased to keep catheter taunt to the patient as outlined in the evidence based bundle.


- Transparency became mainstream for CCH. Outcomes were publicly posted for all to see - physicians, nursing staff and visitors as well as discussed in open forums.

...continued on page 10
Results and Measurement Indicators
Effectiveness of the CAUTI project was strictly based on reduction of CAUTI rates and indwelling urinary device reduction. CAUTI was defined using the Center for Disease Control’s National Healthcare Safety Network (NHSN) definition. NHSN is the nation’s most widely used healthcare-associated infection tracking system. Additionally, indwelling urinary device days were measured. Device days are calculated using the number of indwelling urinary catheter at midnight over patient days. CAUTI rate decreased from 5.72 (FY08) to 0.08 (current FY14), a 99% reduction. Indwelling urinary catheter utilization rate decreased from 3.4 (FY08) to 1.7 (current FY14), a 50% reduction.

Financial Impact
Financial impact of implementing the program was minimal. A one time capital purchase of bladder scanners occurred for the units at a total cost of $6,000. No cost was incurred for education, as staff was in serviced on the program during regular business hours.

Three broad components of cost comprise the socio-economic costs of HAI: direct medical costs, the indirect costs related to productivity and non-medical costs, and intangible costs related to diminished quality of life. Approximately $750 is spent on direct medical cost per CAUTI case (Scott, 2009). Using the U.S. Department of Health and Human Services cost of care calculator, it is estimated that CCH prevented 62 CAUTI cases and saved nearly $46,500 since implementing the CAUTI program.

Lessons Learned
CCH has seen significant reductions in catheter days and more importantly CAUTIs. In addition, the culture of patient safety and transparency has flourished within CCH. Road blocks have been analyzed and processes have been designed to reach the desired outcome. The CAUTI project paved the way for other process improvements and has engaged all leadership levels, frontline staff, physicians and patients.
CAUTI Prevention at CCH

MD daily validation of catheter

CAUTI Prevention at CCH

Daily prevalence of total indwelling catheters

CAUTI Prevention at CCH

Unit based champion weekly audits

AJDT TOOL

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# NALTH COMMITTEES & WORKGROUPS

(as of June 11, 2014)

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**WORKGROUPS**

**CFO Policy Analysis Workgroup**

**Policy & Advocacy Advisory Workgroup**

**Committees – Expanded Lists**
May 1 and 2, 2014 marked NALTH’s 25th annual meeting. This meeting was very successful with 120 individuals attending representing 79% of the association’s membership.

Meeting Highlights:

- The clinical session translating innovative infectious disease care to the LTCH was well received by attendees. Evaluation summary comments indicated strong support for sessions focusing on functional clinical quality topics in addition to policy and regulatory reports.

- The NALTH business meeting provided much opportunity for board and association members’ discussion regarding the status of post acute care reform as well as threats looming on our corner of healthcare. All were in agreement that a focus on advocacy through activity demonstrating the value of LTCH care is critical. At this point in time, this research activity will focus on wound care. 70% of member facilities that responded to the recent NALTH member survey identified wound care matters as the issue of highest priority. The recommendation was for research to address the following three areas: patient wound criteria, patient outcomes, and program resource utilization supporting LTCH placement. To clearly demonstrate the commitment to research and evidence based practice, NALTH will move forward with having the Effects of Long Term Care Hospitals on Outcomes, Utilization, and Payments from Medicare Beneficiaries published in a peer reviewed journal.

- Attendees clearly exhibited anxiety regarding the MedPAC recommendation to expand the number of days in an ICU/CCU for an individual case to qualify for LTCH care from three to eight days.

- The IMPACT and Bundling and Coordinating Post Acute Care (BAPAC) Acts indicate strong support for site neutral payment reform. As an association we must continue to provide input helping to shape or steer this reform highlighting a LTCH’s ability to serve as a low cost hospital in an ACO.

- Investigate the need to establish a Policy & Advocacy Workgroup. The purpose of the Workgroup would be to identify and discuss policy and other issues of concern to members, and to develop recommendations to the board on policy positions and actions steps. The Workgroup would consist of approximately five non-board members and two NALTH board members.

At the close of the meeting there was consensus that as an industry we are at a critical juncture but we cannot let anxiety or fear paralyze us. Instead, we must fight efforts to limit patient access to the care LTCHs are uniquely qualified to provide. This change requires a knowledgeable and united lobbying effort. NALTH remains committed to educating its members on these matters in preparation for this challenge. As a result, the association will provide monthly briefings highlighting areas of focus and activity. In addition, bimonthly member update calls will be initiated. These calls will be held on the third Thursday of the month at 2:00 PM Eastern Time. The first call was held on May 15th with the next call scheduled for July 17, 2014.
For the past 25 years, the National Association of Long Term Hospitals (NALTH) has been at the forefront of policy and healthcare quality discussions related to the long-term care hospital (LTCH) industry. With recent legislative changes and an increased focus on value, LTCHs must adapt to the evolving healthcare environment and demonstrate their role in the continuum of care.

As the only national association advocating exclusively on behalf of LTCHs, NALTH is engaged on many fronts to support its members. These efforts range from effectively communicating the value of LTCH services to policy makers, payers and to advocating for sensible regulations recognizing the important services LTCHs provide to the most critically complex patients. NALTH has also established a committee on quality and research to focus on issues using empirical research to drive sound policy decision-making, such as determining appropriate criteria for wound cases requiring LTCH care.

In addition, NALTH, whose members include both for-profit and not-for-profit LTCHs, will continue to be a vital resource to its members in the coming years. NALTH provides a range of services, including developing resources to help inform members of legislative proposals and regulatory issues, conducting hospital-specific financial impact analyses, and organizing educational conferences for clinicians and hospital leaders.

RESEARCH AND RESOURCES

As a member-driven organization, NALTH has been responsive to members’ needs with respect to advocacy, education, and research. In particular, NALTH has:

- Assessed the impact of the Pathway for SGR Reform Act and provided detailed impact analysis to members.
- Designed a Payment Calculator to assist members in determining future payments under the Pathway for SGR Reform Act.
- Demonstrated LTCH value through a study on outcomes, utilization, and payments for Medicare beneficiaries in LTCHs. The study shows that, for certain types of patients, LTCH care results in savings to the Medicare program, as well as improved outcomes in the form of lower mortality and reduced readmission rates (2013-14).
- Created tools to assist members in navigating the 25-Percent Threshold Rule and LTCH quality measure submission and reporting deadlines.
- Commissioned the only comprehensive, multi-site study of ventilator weaning outcomes in LTCHs, with results published in *Chest, The Cardiopulmonary and Critical Care Journal* (2007).
- Developed and refined LTCH inpatient medical necessity screening criteria for admission, continued stay, and discharge that are utilized by LTCHs across the nation.
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