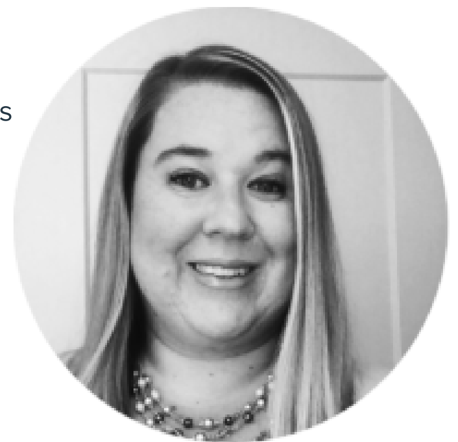
EncoreKeynote

June 2022

Encore's Director of Talent, Curation, and Design

Kathleen Simenton OTR, RAC-CT



Kathleen Simenton is Encore's new Director of Talent, Curation, and Design. She is new to the role of recruiting but is no stranger to the Encore family. Kathleen started her career with us in 2008 as an Occupational Therapist. She has worked at multiple facilities in rural, urban, and suburban areas as both an OTR and a Therapy Program Manager, which has given Kathleen a solid base of understanding of various types of facility needs and challenges. She has also worked in multiple regional roles, the most recent being a Senior Vice President of Operations.

With Kathleen in her new role, we are bridging the gap between operations and recruiting. The recruiting team is learning the life of a therapist on a more intimate level than before. Because of Kathleen's experience in her operations roles, the recruiting team members can come to her with ideas, and she can put the "why" behind some of the things we see in the field. This enhanced partnership generates greater passion and allows us to tell a bigger story.

Recruiting is not just about finding candidates; it is also about being a part of keeping employees here and engaged. Kathleen has helped create a culture committee comprised of all positions in this company to learn what it is our staff needs. As someone who has walked a mile (and then some) in every aspect as a therapist, Encore believes Kathleen is the perfect candidate to lead our organization in this critical role.

WE ARE HIRING

June is Aphasia Awareness Month

2 million people

in the United States have

Aphasia

and have lost all or some of ability to use words

#aphasiaawareness

June is National Aphasia Awareness Month

You may have never heard of the term "Aphasia" until recently. A 2016 survey conducted by the National Aphasia Association indicated that 84.5% of participants had never heard of this term. With the public announcement of Bruce Willis' aphasia diagnosis, this condition has become more searched, more discussed, and has created increased awareness.

To define aphasia: An impairment of language, not intelligence. When considering this definition, you must understand that language has various depths and is a complex system of communication. As humans, we have the ability to understand (receptive) language and express (expressive) language. When there is a breakdown in one or both of these areas, it certainly results in the inability to communicate.

Aphasia has various neurological causes, the most common being stroke or traumatic brain injury which affects the language centers of the brain. When this occurs, our patients may have difficulty understanding directions and answering simple questions due to impaired comprehension and finding the correct word or phrases to formulate their response. Aphasia can affect reading and writing skills, which puts our patients in a unique and frustrating situation. Imagine not being able to tell your loved one "I love you" or telling your nurse that you're in pain. A 2010 study conducted in Canada revealed that "Aphasia has the largest negative impact on quality of life, more than cancer and Alzheimer's Disease." The impact of aphasia on patients and their loved ones is immeasurable.

What can we do? We can raise awareness by talking about preventative stroke interventions and bringing attention to the communication disorders that impact our patients' lives. Seek out information from a Speech-Language Pathologist and include information regarding aphasia to your facility staff. SLPs can guide your facility staff on decreased communication which may prompt a Speech Therapy referral and determine the appropriateness of treatment. Certain signs of aphasia are very noticeable such as trouble with word-finding, difficulty attending to tasks, use of nonsense words or word substitutions, and decreased ability to follow directions. If any of your current patients experience these symptoms it is important to treat the medical condition which is causing the communication breakdown but also to refer to an SLP for evaluation. Even if your patient does not have a history of stroke or TBI, any communication breakdown is a good reason to refer to your facility's therapy department for Speech Therapy.

Speech-Language Pathologists have specialty training in all areas of communication. Depending on the severity of the patient's diagnosis, the SLP may conduct direct treatment targeting expressive and/or receptive language areas to improve verbal communication and comprehension. If the neurological deficit is so severe that the patient's prognosis for verbal communication is poor, the SLP can still facilitate communication. There are many options for Alternative Augmentative Communication (communication devices) and SLPs can complete assessments to make recommendations on which device would be best suited for a particular patient. Ongoing education and device programming continue to be part of the Speech Therapy treatment plan and caregiver involvement is paramount.

Having ongoing communication and awareness of areas that our patients may struggle with will allow your teams to communicate better and more efficiently. Involving Speech Therapy in your patients' rehab process and throughout their lives can directly improve communication and impact their quality of life.

OIG's Report on Some Medicare Advantage Organizations

On 4/27/2022, OIG released the report "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care" which summarizes their findings of the review of a sample of 250 prior authorization denials and 250 payment denials issued by 15 of the largest MAOs during June 1-7, 2019. Health care coding experts conducted case file reviews of all cases, and physician reviewers examined medical records for a subset of cases.

They determined that MAOs sometimes delayed or denied Medicare Advantage beneficiaries' access to services, even though the requests met Medicare coverage rules. MAOs also denied payments to providers for some services that met both Medicare coverage rules and MAO billing rules. Denied requests that meet Medicare coverage rules may prevent or delay beneficiaries from receiving medically necessary care and can burden providers. Although some of the denials reviewed were ultimately reversed by the MAOs, avoidable delays and extra steps create friction in the program and may create an administrative burden for beneficiaries, providers, and MAOs.

They found that among the prior authorization requests that MAOs denied, 13 percent met Medicare coverage rules; in other words, these services likely would have been approved for these beneficiaries under original Medicare (also known as Medicare fee-for-service). They found that among the payment requests that MAOs denied, 18 percent of the requests met Medicare coverage rules and MAO billing rules. Finally, they also found that MAOs reversed some of the denied prior authorization and payment requests that met Medicare coverage and MAO billing rules. Often the reversals occurred when a beneficiary or provider appealed or disputed the denial, and in some cases, MAOs identified their own errors.

Reference:
https://www.oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf

Update to COVID-19 Emergency Declaration Blanket Waivers for Specific Providers

Waivers ended May 7, 2022

> Resident Groups - 42 CFR §483.10(f)(5) - CMS waived the requirements which ensure residents can participate in-person in resident groups. This waiver permitted the facility to restrict in-person meetings during the COVID-19 PHE. Physician Delegation of Tasks in SNFs - 42 CFR §483.30(e)(4). CMS waived the requirement that prevents a physician from delegating a task when the regulations specify that the physician must perform it personally. This waiver gave physicians the ability to delegate any tasks to a physician assistant, nurse practitioner, or clinical nurse specialist, but specified that any task delegated under this waiver must continue to be under the supervision of the physician.

> Physician Visits - 42 CFR §483.30(c)(3). CMS waived the requirement that all required physician visits (not already exempted in §483.30(c)(4) and (f)) must be made by the physician personally. The waiver modified this provision to permit physicians to delegate any required physician visit to a nurse practitioner, physician assistant, or clinical nurse specialist who is not an employee of the facility, who is working in collaboration with a physician, and who is licensed by the State and performing within the state's scope-of-practice laws.

> Physician Visits in Skilled Nursing Facilities/Nursing Facilities - 42 CFR §483.30. CMS waived the requirement for physicians and non-physician practitioners to perform in-person visits for nursing home residents and allow visits to be conducted, as appropriate, via telehealth options.

> Quality Assurance and Performance Improvement (QAPI) – 42 CFR §483.75(b)–(d) and (e)(3). CMS modified certain requirements which require long-term care facilities to develop, implement, evaluate, and maintain an effective, comprehensive, data[1]driven QAPI program. This waiver gave providers the ability to focus on adverse events and infection control, and those aspects of care delivery most closely associated with COVID-19 during the PHE.

> Detailed Information Sharing for Discharge Planning for Long-Term Care (LTC) Facilities - 42 CFR §483.21(c)(1)(viii). CMS waived the discharge planning requirement which requires LTC facilities to assist residents and their representatives in selecting a post-acute care provider using data, such as standardized patient assessment data, quality measures and resource use. CMS maintained all other discharge planning requirements.
> Clinical Records - 42 CFR §483.10(g)(2)(ii). CMS modified the requirement which requires long-term care (LTC) facilities to provide a resident a copy of their records within two working days (when requested by the resident).

Waivers ending June 7, 2022

> Physical Environment for SNF/NFs - 42 CFR §483.90. CMS waived requirements to allow for a non-SNF building to be temporarily certified and available for use by a SNF in the event there were needs for isolation processes for COVID-19 positive residents, which may not be feasible in the existing SNF structure to ensure care and services during treatment for COVID[1]19, provided that the state has approved the location as one that sufficiently addresses safety and comfort for patients and staff. Certain conditions of participation and certification requirements for opening a NF if the state determines there is a need to quickly stand up a temporary COVID-19 isolation and treatment location. Requirements to temporarily allow for rooms in a long-term care facility not normally used as a resident's room, to be used to accommodate beds and residents for resident care in emergencies and situations needed to help with surge capacity.
> Equipment Maintenance & Fire Safety Inspections for ESRD facilities - 42 CFR 494.60(b) and(d). CMS waived the requirement for on-time preventive maintenance of dialysis machines and ancillary dialysis equipment. Additionally, CMS waived the requirements for ESRD facilities to conduct on-time fire inspections.
Facility and Medical Equipment Inspection, Testing & Maintenance (ITM) for Inpatient Hospice, ICF/IIDs and
> SNFs/NFs – 42 CFR §§418.110(c)(2)(iv), 483.470(j), and 483.90. CMS waived ITM requirements for facility and medical equipment to reduce disruption of patient care and potential exposure/transmission of COVID-19.
Life Safety Code (LSC) and Health Care Facilities Code (HCFC) ITM for Inpatient Hospice, ICF/IIDs and SNFs/NFs - 42 CFR §§ 418.110(d)(1)(i) and (e), 483.470(j)(1)(i) and (5)(v), and 483.90(a)(1)(i) and (b). CMS waived ITM required by the LSC and HCFC, with specified exceptions, which permitted facilities to adjust scheduled ITM frequencies and activities to the extent necessary.
> Outside Windows and Doors for Inpatient Hospice, ICF/IIDs and SFNs/NFs – 42 CFR §418.110(d)(6), 483.470(e)(1)(i), and 483.90(a)(7). CMS waived the requirement to have an outside window or outside door in every sleeping room. This permitted spaces not normally used for patient care to be utilized for patient care and quarantine.
> Life Safety Code for Inpatient Hospice, ICF/IIDs, and SNFs/NFs - 42 CFR §§418.110(d), 483.470(j), and 483.90(a). CMS waived these specific LSC provisions: Fire Drills: Due to the inadvisability of quarterly fire drills that move and mass staff together, CMS permitted a documented orientation training program related to the current fire plan, which considered current facility conditions. Temporary Construction: CMS waived requirements that would otherwise not permit temporary walls and barriers between patients.
> Paid Feeding Assistants for LTC facilities: 42 CFR §§483.60(h)(1)(i) and 483.160(a). CMS modified the requirements regarding required training of paid feeding assistants to allow that training can be a minimum of one hour in length. CMS did not waive other requirements related to paid feeding assistants or required training content.
> In-Service Training for LTC facilities – 42 CFR §483.95(g)(1). CMS modified the nurse aide training requirements for SNFs and NFs, which required the nursing assistant to receive at least 12 hours of in-service training annually.
> Training and Certification of Nurse Aides for SNF/NFs - 42 CFR §483.35(d) (Modification and Conditional Termination). CMS waived the requirements which require that a SNF and NF may not employ anyone for longer than four months unless they met the training and certification requirements under §483.35(d). CMS previously provided information related to nurse aides working under this blanket waiver in CMS memorandum QSO-21-17 - This memo provides additional information as well on the modification of this waiver below. CMS states that all nurse aides, including those hired under the above blanket waiver at 42 CFR §483.35(d), must complete a state approved Nurse Aide Competency Evaluation Program (NATCEP) to become a certified nurse aide. CMS is aware that there may be instances where the volume of aides that must complete a state approved NATCEP exceed the available capacity for enrollees in a training program or taking the exam. This may cause delays in nurse aides becoming certified. If a facility or nurse aide has documentation that

demonstrates their attempts to complete their training and testing (e.g., timely contacts to state officials, multiple attempts to enroll in a program or test), a waiver of these requirements (42 CFR §483.35(d)) is still available and the aide may continue to work in the facility while continuing to attempt to become certified as soon as possible. However, for all other situations, this waiver is terminated. When capacity issues exist, facilities should inform their state officials of the issue. State agencies should also verify the capacity issues that are reported. Lastly, state agencies should provide their CMS Location with information about the status of their NATCEPs.

Reference: https://www.cms.gov/files/document/qso-22-15-nh-nltc-lsc.pdf

June is also National Healthy Home Month

National Healthy Homes Month was created by the U.S. Department of Housing and Urban Development (HUD) as a way to promote awareness of the housing-related health and safety hazards that exist in many homes.

As our residents transition from the SNF to their next level of care, whether it be in an Independent Living center, Assisted Living community or their own home, maintaining safety is of great importance.

Seven Tips for Keeping a Healthy Home – U.S. Department of Housing and Urban Development (HUD)

1. **Keep it dry:** prevent water from entering the home through leaks and otherwise
2. **Keep it clean:** contain the source of dust and contaminants
3. **Keep it safe:** secure loose rugs, install smoke and carbon monoxide detectors, keep fire extinguishers on hand
4. **Keep it well-ventilated:** ventilate bathrooms and kitchens, supplying fresh air to reduce concentration of contaminants in the home
5. **Keep it pest-free:** keep food and liquid in pest-resistant containers
6. **Keep it contaminant-free:** keep floors and window areas clean, test the home for radon
7. **Keep it well-maintained:** inspect, clean and repair the home routinely

Why are Healthy Homes Important?

Americans spend 90% of their time indoors, which means they are extremely influenced by their indoor environments. The air quality, water quality, organization and set-up of the home can all have an impact on health implications, according to HUD.

What can we do to keep our residents safe?

Prior to transitioning residents to their next level of care, therapists can perform home safety assessments with residents and family members without ever leaving the facility. Safety assessments can be completed using a home checklist that includes topics such as:

- Uneven walking surfaces
- Clutter
- Inadequate lighting
- Light switches and electrical outlets
- Furniture arrangement
- Floors and stairs
- Heating units and water heater
- Bedroom and bathroom areas
- Kitchen set-up

For additional healthy homes safety information, be sure to reach out to your therapy team. Resident and family education and training can significantly impact the health and wellness of our residents as they move from our SNF communities into their next stage of recovery.