T-29 Hot Topics in Assisted Living

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Learning Objectives

• Understand what activities federal policymakers are undertaking that affect assisted living.
• Define state and national industry, regulatory and legislative trends and developments.
• Understand national initiatives related to assisted living quality.

National Study of Long-Term Care Providers

✓ Conducted by the National Center for Health Statistics (CDC)
✓ Includes: Adult Day Centers, Nursing Homes, Residential Care Communities, Hospice, & Home Health Agencies
✓ Report available at: cdc.gov/nchs/nsltcp.htm
Average Hours Per Resident by Provider Type and Staff Type

Percentage of LTC Providers that Provide Mental Health Counseling

Percentage of LTC Providers that Provide Therapeutic Services
Percent of Providers that Provide Skilled Nursing/Nursing Services

Hospice Services

Long-term Care Users: By Age & Provider
LTC Users: Daily Use of Residential Care

Age of Long-Term Care Users

LTC Service Users by Sex
LTC Service Users by Race & Ethnicity

Depression & Dementia

Assistance with ADLs in LTC -- 2012
Assisted Living ADLs -- 2010

Common Chronic Conditions in RCFs -- 2010

How much does LTSS Cost in Ohio?

<table>
<thead>
<tr>
<th>Service</th>
<th>Ohio Median</th>
<th>National Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lic. Home Care</td>
<td>$43,472</td>
<td>$45,188</td>
</tr>
<tr>
<td>Adult Day</td>
<td>$13,520</td>
<td>$16,900</td>
</tr>
<tr>
<td>ALF Single</td>
<td>$47,646</td>
<td>$42,000</td>
</tr>
<tr>
<td>NF Semi-Pvt.</td>
<td>$75,942</td>
<td>$77,380</td>
</tr>
<tr>
<td>NF Private</td>
<td>$87,180</td>
<td>$87,600</td>
</tr>
</tbody>
</table>

Source: Genworth 2014 Cost of Care Survey
What is your opinion of...

![Survey Results Diagram](image)

Where would you want your 30 days of therapy to take place?

![Survey Results Diagram](image)

Medicaid & Assisted Living

Major Challenges include:

- Rates often inadequate.
- Payment for AL incomplete (housing, food, utilities not covered; SSI check insufficient to fill gap).
- States rapidly shifting to managed care.
- Assisted living will need to adapt to CMS’ new rules pertaining to Medicaid waiver programs.
Home & Community-based Services (HCBS) as a Percentage of Medicaid LTC Spending

<table>
<thead>
<tr>
<th>State</th>
<th>Percent HCBS</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Mex.</td>
<td>83.2%</td>
</tr>
<tr>
<td>Iowa</td>
<td>39.8%</td>
</tr>
<tr>
<td>Ohio</td>
<td>32.5%</td>
</tr>
<tr>
<td>New York</td>
<td>46.7%</td>
</tr>
<tr>
<td>Miss.</td>
<td>14.4%</td>
</tr>
</tbody>
</table>


CMS Final Rule (1915 c, k, & i) Executive Summary

- Flexibility to combine populations and align waiver authorization periods likely will
  - Further foster development of managed care arrangements
  - Eliminate administrative barriers to further HCBS expansion
- Availability of a final Section 1915(i) rule with budgetary control clarifications may increase state interest
- For Assisted Living delivered under 1915(c), (i), or (k), the HCBS setting definition is improved notably over proposed rules
- New public notice and input requirements will provide new opportunities to provide input and require state responses to such input including on changes considered “Substantive”

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Under the Final CMS Rule, HCBS Settings Must:

- Be integrated in and support full access to the greater community
- Be selected by individual from among setting options
- Ensure right to privacy dignity and respect and freedom from coercion and restraint
- Optimize autonomy and independence in making life choices
- Facilitate choice regarding services and who provides them

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Additional Requirements for Provider Owned & Controlled Settings

- Individual has a lease or other legally enforceable agreement providing similar protections
- Right to privacy in the sleeping or living unit
- Lockable entrance doors with individual and appropriate staff having keys
- Freedom to furnish and decorate unit
- Control over his/her own schedule including access to food 24/7
- Individual may have visitors at any time
- Setting is physically accessible

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Modifications to Additional Requirements for Provider Owned & Controlled Settings

- Must be supported by specific assessed need
- Justified in the person-centered service plan
- Documented in the person-centered service plan

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Documentation of Modifications Must be Included in the Service Plan

- Specific individualized assessed need
- Prior interventions and supports including less intrusive methods
- Description of condition proportionate to assessed need
- Ongoing data measuring effectiveness of modification
- Established time limits for periodic review of modifications
- Individual’s informed consent
- Assurance that interventions and supports will not cause harm

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Settings That are not HCBS

- A nursing facility
- An institution for mental diseases
- An intermediate care facility for individuals with intellectual disabilities
- A hospital
- Any other locations that have qualities of an institution

Settings Presumed NOT to be HCBS

- Settings in a publicly or privately-owned facility providing inpatient treatment
- Settings on the grounds of, or adjacent to, a public institution
- Settings with the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCBS

Key Dates

- Published in the Federal Register on January 16, 2014
- Effective March 17, 2014
- States will have one year to submit written plans for bringing existing HCBS programs into compliance
- CMS may approve transition plans for a period of up to five years as supported by individual state circumstances
- New plans must meet the new requirements
CMS Resources

✓ Website: www.medicaid.gov/HCBS
✓ Four Fact Sheets & the Rule are located on the Web site
✓ Mailbox for Questions: HCBS@cms.hhs.gov

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NCAL’s Policy Priorities

▪ Keep Regulation at the state level
▪ Implementation of the new CMS’ definition of Medicaid HCB settings
▪ Protect, Improve Medicaid Coverage
▪ Ensure that AL thrives in an episodic payment/ACO Environment
▪ Help Members navigate health care reform
▪ Make the move to EHRs
▪ Demonstrate that we can manage quality
▪ Diabetic testing supply issues

Innovative Survey Models

✓ Colorado: On Jan. 1, 2013, the Assisted Living Residence (ALR) program began conducting risk-based re-licensure inspections, initially on a pilot basis.

▪ Under the new system, ALRs meeting the following criteria will be eligible for an extended survey cycle: licensed for at least three years, and, within that prior three years, having had no enforcement activity, no pattern of deficient practice, and no significant deficiency cited in response to a complaint that negatively affected the life, health, or safety of residents.
Innovative Survey Models (2)

- **New Jersey:** In 2012, the state Department of Health (DOH) collaborated with The Health Care Association of New Jersey Foundation to create a voluntary program titled Advanced Standing. To receive the department’s distinction of Advanced Standing, a facility must comply with all applicable local, state, and federal regulations as well as submit quality data that reaches benchmarks established by a peer review panel.

- A facility participating in the program does not receive a routine survey by DOH. However, any time a facility falls below DOH standards, such as poor performance on a complaint investigation, that facility can be removed for cause from the program by DOH. In addition, DOH provides follow-up surveys based on a random sample of facilities that participate in the program. The program is open to all licensed assisted living residences and comprehensive personal care homes.

Innovative Survey Models (3)

Other Innovative Assisted Living State Oversight Models:

- **North Carolina:** recently extended survey cycle to two years for “Four-Star” assisted living facilities. Those with highest rating can be inspected every two years instead of annually.

- **Wisconsin:** has abbreviated survey for consistently good performers (based on outcomes reported to the state)

- Many state agencies continue dealing with limited resources, personnel changes.

Federal Regulation of AL

- Over the past years, the U.S. Senate Aging Committee has focused several hearings on AL quality of oversight.

- In 2012, Sen. Bill Nelson (D-FL) considered introducing disclosure legislation after Florida legislature failed to act following a breakdown in the state’s AL regulatory system detailed by Miami Herald series.

- Sen. Nelson now chair of Aging Committee and AL likely to be a focal point of committee attention.

- “Frontline” investigative report on AL aired July 2013 and may increase scrutiny by the media. California is a focus.
Navigating the New Alphabet Soup

- ACO
- MCO
- OIG
- ACA
- HIT
- EHR
- EMR
- HIE
- HIE (but now you call me "HIX" if you mean insurance)
- LTSS
- Response: (LOL, OMG,)

Accountable Care Organizations

Advice from Hospital Sector Analysts...

- Engage Early
- Bring Data
  - Hospital Discharges
  - Discharges to their Hospital
  - DRGs (Resident conditions)
- Make an Investment (time & money)

ACOs will narrow who they work with and increase volume with their partners

Quality has Become and Will Continue to be a Reimbursement Issue

- Reimbursement tied to outcomes
- Examples:
  - ACO’s
  - Medicaid P4P
  - Changing consumer expectations
- The key is the ability to adjust to metrics payers care about
- This will vary by market
Federal Agencies with Initiatives Impacting Assisted Living

- OIG looking at Hospice Care in Assisted Living
- CDC – Infection Control + Hepatitis B Outbreaks
- AHRQ – LTSS Public Reporting
- DOL Wage and Hour Enforcement
- NLRB – Changes to Unionization Rules
- OSHA – Increased Tracking of Workplace Injuries

Federal Agencies with Initiatives Impacting Assisted Living

- DEA – Disposal of Controlled Substances
- EPA Disposal of Medications
- FDA Disposal of Narcotics and Fentanyl patches
- CPSC Ban on Portable Bedrails in Assisted Living
- CMS Implementation of the Final Definition of HCB Setting
- EPA Energy Star Program
- CFPB Efforts on Senior Fraud and Scams

Fair Labor Standards Act Enforcement Continues in LTC Settings including AL

- Working before and after shifts
- Working during an employee’s scheduled meal break including interruptions of short duration
- Employees not being paid for staff meetings and compensable training session

Why the violations?

- Lack of understanding of the FLSA
- “We did it that way the last place I worked”
- Caring employees
- LTC culture and environment
LTC Specific Fact Sheets are Available at:
www.dol.gov/whd

- #31 Nursing Care Under the FLSA (Guidance applicable to all provider types)
- #52 Youth Employment
- #53 Hours Worked
- #54 Calculating Overtime

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Health Information Technology will Transform Assisted Living and All Health Care

- EHR: electronic health record – across health care organizations
- EMR: electronic medical record – within a health organization
- eMAR: technology that automatically documents the administration of medication into certified EHR technology using radio frequency ID or bar coding
- HIE: health information exchange across providers, purchasers, regulators
- HIE–HIX: health insurance exchange
- m-Health: health care through mobile devices

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What Does Interoperability Mean?

- Basic interoperability: ability to electronically communicate health data
- Semantic interoperability: enable the receiving computer to display the text or data received AND accurately interpret the meaning of the data
- Levels of Interoperability:
  - Non-electronic data (paper)
  - Machine transportable data (fax/e-mail)
  - Machine-organizable data (structured messages, unstructured content – documents and images)
  - Machine-interpretable data (structured messages, and standardized content) – Ultimate Goal!

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Life Safety – a Major Breakthrough

✓ Four-year effort led by NCAL’s life safety engineer succeeded in updating and harmonizing two major life safety standards for assisted living:
  • Key committees of the International Code Committee recently adopted similar standards for new construction in 2012.

Life Safety Standards

✓ The new standards address major issues:
  • As residents become less able to evacuate without assistance, the standards allow AL facilities to remain in residential classification while ensuring high level of safety.
    o Results in major cost savings for many providers and improved quality of life for residents who won’t have to move to institutional settings.
  • Over time most states adopt these two bodies’ standards. NCAL generally recommends adoption of 2012 edition of Life Safety Code.

Liability: CNA Analysis of Allegations at Assisted Living Facilities

Allegations at AL Facilities

Highest Frequency Closed Claims:

✓ Resident fall 46.2%
✓ Abuse 9.5%
✓ Pressure ulcer 7.7%
✓ Elopement 7.1%
✓ Improper care 7.1%

Death occurred in 37.2% of the closed claims associated with falls.

“AGING SERVICES 2013: Data Analysis Supporting the Need for Industry Change.”
### Liability: CNA Analysis of Allegations at Assisted Living Facilities (2)

**Allegations at AL Facilities**

**Highest Average Total Paid for Closed Claims:**
- Gross improper care $541,908
- Elopement $378,312
- Failure to follow physician's order $360,939
- Delay in seeking medical treatment $256,309
- Pressure ulcer $251,370

*Source: Aging Services 2012: Data Analysis Supporting the Need for Industry Change,* CNA.

### Liability: CNA Analysis of Injuries at Assisted Living Facilities

**Injuries at AL Facilities**

**Highest Frequency Closed Claims:**
- Death 37.3%
- Fracture(s) 32.5%
- Pain and suffering 6.5%
- Emotional distress 4.1%
- Contusion/bruise 4.1%

*Source: Aging Services 2012: Data Analysis Supporting the Need for Industry Change,* CNA.

### Liability: CNA Analysis of Injuries at Assisted Living Facilities (2)

**Injuries at AL Facilities**

**Highest Average Total Paid for Closed Claims:**
- Death $291,060
- Emotional distress $230,926
- Contusion/bruise $215,590
- Loss of limb/amputation $188,080
- Fracture(s) $174,469

*Source: Aging Services 2012: Data Analysis Supporting the Need for Industry Change,* CNA.
### HealthCap Resolved Claims

**2001 – 2011**

<table>
<thead>
<tr>
<th>Cause</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fractures/Head Injuries</td>
<td>47%</td>
</tr>
<tr>
<td>Minor/No Injury</td>
<td>31%</td>
</tr>
<tr>
<td>Sudden/Unexpected Death</td>
<td>6%</td>
</tr>
<tr>
<td>Pain/Suffering</td>
<td>3%</td>
</tr>
<tr>
<td>Burns</td>
<td>2%</td>
</tr>
<tr>
<td>Sexual Assault</td>
<td>2%</td>
</tr>
<tr>
<td>Pressure Ulcer</td>
<td>1%</td>
</tr>
</tbody>
</table>

### Average Paid for Closed Claims

<table>
<thead>
<tr>
<th>Cause</th>
<th>Average Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choking</td>
<td>$214,168</td>
</tr>
<tr>
<td>Burns</td>
<td>$203,580</td>
</tr>
<tr>
<td>Unexpected Death</td>
<td>$145,470</td>
</tr>
<tr>
<td>Pressure Ulcer</td>
<td>$133,503</td>
</tr>
<tr>
<td>Pain &amp; Suffering</td>
<td>$92,050</td>
</tr>
<tr>
<td>Sexual Assault</td>
<td>$63,769</td>
</tr>
<tr>
<td>Fractures/Head Inj.</td>
<td>$49,416</td>
</tr>
</tbody>
</table>

*HealthCap (2001 to 2011 Data)*

### What Led to the Litigation?

Source: “HealthCap Data based on resolved claims from 2001-2011 for residential care/assisted living/independent living

**Common causes:**

- Fractures and head injuries primarily due to falls
- Sudden/unexpected deaths due to unnoticed change of conditions, elopements, bedrails and medication errors.
- Burns due to cigarette smoking and inappropriate use of hot packs
Rising Acuity: Meeting the Challenges

- With increasing acuity of AL residents it is important to be able to provide quality care
- Data collection will be key in identifying areas your community is excelling in and areas that need improvement
- Health care is rapidly changing to integrated health care models such as ACOs
- Hospitals are concerned with readmission penalties and looking to partner with providers with low readmission rates

NCAL Quality Initiative Goals

- Safely reduce 30-day hospital readmissions by 15% by 2015
- Maintain nursing staff turnover below 30% until 2015
- Maintain customer satisfaction above 90% by 2015
- Safely reduce the off-label use of antipsychotics by 15% by 2015
**Safely Reduce Hospital Readmissions**

**Target:** By March 2015, individual communities will safely reduce hospital readmissions by 15 percent (this includes any admitting diagnosis).

Individual communities that have less than 5 percent of residents with hospital readmissions will maintain hospital readmissions below 5 percent.

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**Using Counts: “Time Between Events”**

- Simple counts
  - # of hospitalizations last week
- Time between events (e.g., OSHA employee injuries)
  - # of days since last hospitalization
- Use for any clinical measure:
  - As you increase the time between events you will improve on any quality measure risk adjusted or not
  - Simple
  - Easy to display where all staff can see
  - Rapid feedback

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**Tracking Counts & Time Between Events**
Hospital Readmissions: Achieving the Goal

- Adopt the INTERACT program
- Ensure seamless information exchanges between providers through the use of electronic health records (EHRs)
- Engage providers at all points throughout the spectrum of care.
- Expand the use of nurse practitioners
- Use consistent assignment of staff to ensure that staff are familiar with residents’ normal patterns and characteristics so that they detect early changes in resident’s conditions before they lead to a hospitalization
- Utilize the tools on the Quality Initiative for Assisted Living website

Hospital Readmissions: The Business Case

- Decreases hospital acquired infections, resulting in less opportunity for skin breakdown, injury or harm from transfers.
- Decreases the exacerbation of symptoms for people with dementia.
- Means less stress for nurses who must take time for the readmission and transfer requirements.
- Better outcomes make your facility more attractive as a preferred provider in integrated care models (such as ACOs)

Hospital Readmissions: Resources

- Business Case
- Measurement Summary
- INTERACT
  - SBAR for Assisted Living Nurses
  - SBAR for Assisted Living Caregivers
  - Stop & Watch
  - Measurement of Hospital Transfer Rate
  - INTERACT Change in Condition Card

Resources available at qualityinitiative.ncal.org
Tips on Implementing Stop & Watch

- Stop & Watch
  - Send staff to learn from another facility using tool
  - Pilot test 1 team on 1 unit
  - Let team decide how to use stop & watch
  - Meet with pilot team daily for feedback
  - Make changes based on feedback
- Start with CNA – Nurse using
  - Gradually expand to other staff, then to families
  - 6 months to successfully roll out Stop & Watch

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Tips on Implementing Stop & Watch

- Need to work with staff to remind them to complete stop & watch
- Need to work with RN’s to follow-up on submitted stop & watch
- Look at stop & watch forms (or lack thereof)
- Engage Physicians
  - Support notification of MDs/NPs on early signs

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Increase Staff Stability

Target: Each year, until March 2015, maintain nursing staff turnover rates below 30 percent.

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Staff Stability: Resources

- Staff Turnover Calculator (Excel Spreadsheet)
- Introducing Peer Mentoring in Long-Term Care Settings
- Staff Stability toolkit (available in the AHCA/NCAL Bookstore!)

Resources available at qualityinitiative.ncal.org

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Increase Customer Satisfaction

Target: By March 2015, maintain the number of customers who would recommend the community to others at or above 90 percent.

Communities with customer satisfaction below 90 percent should improve to 90 percent by March 2015

Customer Satisfaction: Resources

- Measurement Summary
- Business Case
- Presentations and Guides
  - Better Serving the Lesbian, Gay, Bisexual, and Transgender Populations in AL
  - Preparing Residents to Move Out
  - Making Resident and Family Councils Successful in AL
  - Turning Complaints into Compliments
  - The Power of Ethical Marketing

Resources available at qualityinitiative.ncal.org

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Safely Reduce Off-Label Use of Antipsychotics

Target: By March 2015, safely reduce off-label use of antipsychotics by 15 percent.

Communities that have less than 5 percent of off-label use maintain rates at or below 5 percent.

All communities will implement use of at least one tool aimed at reducing off-label use of antipsychotics by March 2015.

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Antipsychotic Medications

Convention (Generic)
- Halol (Haloperidol)
- Leusrane (Loxapine)
- Navane (Thiothixene)
- Orao (Pimozide)
- Compazine (Prochlorperazine)
- Mellaril (Thoridazine)
- Molan (Molindone)
- Prolidine (Fluphenazine)
- Stelazine (Thiothixene)
- Thorazine (Chlorpromazine)

Atrypical (Generic)
- Abilify (Aripiprazole)
- Saphris (Asenapine)
- Clozaril (Fazadin Clozapine)
- Fanopt (Iloperidan)
- Zypraxa (Olanzapine)
- Invega (Paliperdone)
- Serquel (Quetiapine)
- Risperdal (Risperidone)
- Geodon (Ziprasidone)
FDA approved diagnoses

- Schizophrenia
- Bipolar Disorder
- Irritability associated with Autistic Disorder (Aripiprazole & Risperidone)
- Treatment Resistant Depression (Clonazepam)
- Major Depressive Disorder (Quetiapine)
- Tourettes (Orap)

When prescribed to a patient without an FDA approved diagnosis; considered off-label use, which is allowed by FDA and Medical Boards

Common Off-label uses

- Dementia with behavior difficulties
  - Agitation
  - Aggression
  - Wandering
- Acute Delirium
- Depression
- Obsessive-compulsive disorder
- Psychotic symptoms (e.g. hallucinations, delusions) with neurological diseases
  - Parkinson's disease
  - Stroke

Effectiveness in Dementia

- Antipsychotic effect takes 3-7 days
  - Acute response most likely due to sedating properties, not antipsychotic effect
- In RCTs, recipients do a little bit better than placebo but the effect beyond 3 months is unclear and:
  - Not everyone who receives the meds improves
  - A large number of people getting the placebo improve
  - The net effect is that 10 to 20 people out of 100 who receive the medication improve due to the medication
Associated with Adverse Outcomes

- Off-label use of antipsychotics in nursing facility residents is associated with increase in:
  - Death (heart failure or pneumonia) 1.6 x greater than placebo
  - Hospitalization (40% increase)
  - Falls & fractures
  - Venothrombotic events
- Conventional antipsychotics are worse than atypical antipsychotics

Effectiveness with Low Doses

- Low dose Risperidone (<1 mg/d): small positive effect but also increased risk of adverse events
- Low dose Olanzapine (5 mg/d): no positive effect but does have increased risk of adverse events
- Low dose Aripiprazole and Quetiapine: effectiveness unknown, but Quetiapine at normal dose has no evidence of effectiveness

FDA Black Box Warning

- Issued in 2005
- Warning: Increased Mortality in Elderly Patients with Dementia-Related Psychosis
  - Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. [Name of Antipsychotic] is not approved for the treatment of patients with dementia-related psychosis.
Antipsychotics: The Business Case

- Decreases the side effects and adverse drug reactions associated with these medications.
- Non-pharmacologic interventions help to enhance an individual's ability to direct their care, which improves their independence, dignity, and quality of life.
- Adverse Drug Events (ADEs) may require hospitalization and the community may experience lost revenue for days the resident is not in the community.
- A reputation for using innovative, person-centered care approaches will provide a competitive advantage.

Antipsychotics: Achieving the Goal

- Focus on non-pharmacologic approaches for preventing the frustrations that can lead to challenging behavior and for addressing resident's behavioral expressions when they do occur.
- Using a positive physical approach, engaging residents in meaningful activity, and using therapeutic strategies for catastrophic events can make a real difference for residents with dementia.
- Environmental changes: reducing noise, improving lighting, and allowing flexible scheduling.

Antipsychotics: Resources

- Qualityinitiative.ncai.org
- Measurement Summary
- Business Case
- Antipsychotic Consumer Fact Sheet
- CEAL Clearinghouse www.theceal.org
- Alzheimer's Association
- IA-ADAPT https://www.healthcare.uiowa.edu/igec/iaadapt/
SBAR for Antipsychotics

SBAR for Assisted Living
Prohibited/Do Not Order: Antipsychotics for 60 Days
To identify possible drug interactions for an individual and make necessary interventions.

S
Situation: The drug and behavior (if possible) the resident are experiencing.

B
Background: The patient's current condition, including any comorbidities.

A
Assessment: The resident's current mental state and any behavioral changes.

R
Recommendations: The appropriate interventions and actions to take.

Getting Started on the Quality Initiative

✓ Visit qualityinitiative.naci.org for tools to help you achieve the four goals
✓ Share the goals!
  ▪ Review the goals and educate your team including department managers, owners, staff, and residents
✓ Download the measurement summaries for each goal

Getting Started on the Quality Initiative, continued

✓ Download the business cases for each goal
✓ Start tracking hospital readmissions
✓ Start measuring the number residents that are on antipsychotics with an off-label use
✓ Start measuring resident satisfaction
✓ Start tracking turnover
“In God we trust, all others bring data” – Elements of Statistical Learning

What is a PSO?

- PSOs serve as a group of independent, external experts who can collect, analyze, and aggregate Patient Safety Work Products locally, regionally, and nationally to develop insights into the underlying causes of patient safety events.
- Communications with PSOs are protected from disclosure to allay fears of increased risk of liability because of collection and analysis of patient safety events.
- PSOs are certified by the Agency for Healthcare Research & Quality (AHRQ)

Benefits of Partnering with a PSO

- Improve safety and quality leading to better resident outcomes
- Participate in a non-punitive reporting system that is designed to reduce or minimize harm to residents
- Contribute to national safety initiatives
- Reduce liability costs and exposures
- Detect and address emerging quality issues as they arise
- Data for the AHCA/NCAL Quality Award Program
What Data will the PSO Collect?

- Demographics
  - Number of residents with dementia at the end of the target month
  - Number of residents with mental health diagnosis other than dementia or depression
  - Average age of current residents at the end of the month

- Falls
  - Process measure: Initial assessment for fall risk
  - Outcome measure: Falls with harm resulting in hospitalization

- Pain Management
  - Outcome: Pain unrelieved by medication

- Pressure Ulcers
  - Process: Pressure ulcer risk & skin assessment
  - Outcome: In-house acquire pressure ulcers

- Infection Control
  - Process measure: Number of residents receiving influenza vaccine
  - Outcome measure: Reported urinary tract infection

- Medication Management
  - Process: Incidence of off-label use of antipsychotics
  - Process: Prevalence of off-label use of antipsychotics
  - Outcome: Medication errors
What Data will the PSO Collect?

- Unplanned Hospitalizations
  - Process: residents screened for risk of hospital admission
  - Outcome: number of all-cause, unplanned hospitalizations

- Hospice:
  - Process: number of residents with advanced directives
  - Outcome: number of residents enrolled in hospice

What Data will the PSO Collect?

- Elopements
  - Outcome: cases of elopement

- Depression
  - Process: number of residents screened for depression within 14 days
  - Outcome measure: number of residents who were referred for f/u

PSO Data Collection
PSO Data Collection

**Note that multi-community entities with less than 100 units will pay $35 per unit with a maximum annual compensation of $3,500.**

Units: A residential unit is defined as a separate apartment or unit for one or more persons. Such unit may include its own kitchen, bathroom, and sleeping area or bedroom.

23 or less units: $35 per unit with a $250 minimum
26 or more units: $35 per unit with a maximum annual compensation of $3,500
Multi-community Entities (with 100+ units): $3,500 for the first 2 communities plus $800 for each additional community
Learn More & Sign Up

Want to learn more or sign up for the PSO? Visit ncalpsao.org

Questions about the PSO?

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Director, Workforce and Quality Improvement
1201 L Street N.W. Washington, DC 20005
202-898-2848
lschwartz@ncal.org

Final Thoughts on the Future...

• We are embarking on era of tremendous change that will transform traditional assisted living operations
  • Increased focus on health care
  • More physician involvement
  • Hospitals, MCOs and ACOs will steer
  • Staffing (quality and quantity)
  • Quality performers will win...but only if they prove their success with data
  • Diversification and specialization
  • New affiliations and partners