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Ohio Civil Money Penalty Reinvestment Program

**Project Application – Nursing Facility Competency Certification
Recommended to CMS September 17, 2019**

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1. Purpose and Summary

Project Purpose: The purpose of this project is to provide nursing facilities with competency-based training for improved patient care per the updated CMS Requirements of Participation for nursing facilities that became effective in November of 2017.

Of the many changes required, this project addresses the need for documented evidence of nursing services staff competency. Facilities, therefore, are now tasked with validating that each nursing services staff person is competent in their assigned position. The CMS State Operations Manual Appendix PP "Guidance to Surveyors for Long Term Care Facilities" outlines the requirements at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf.

Specifically, §483.35 Nursing Services states:
The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e)…

Furthermore,
…Competency may not be demonstrated simply by documenting that staff attended a training, listened to a lecture, or watched a video. A staff's ability to use and integrate the knowledge and skills that were the subject of the training, lecture, or video must be assessed and evaluated by staff already determined to be competent in these skill areas. The intent is to promote resident's rights and physical/mental/psychosocial well-being. §483.35(a)(3)-(4)(c)

Given the updated requirements, nursing facilities have expressed to their membership organizations that they are struggling with meeting the requirement for competency-based training programs. Currently, nursing facility training programs are typically passive and routine, with online training modules or lecture driven in-services the norm. Adding the additional requirement to assess competency via requiring return demonstrations and/or observation of multiple competency variables requires training for a skill set new to most facilities. PMR started providing training on various requirements of participation in 2016 and

has conducted competency program specific training via workshops through LeadingAge Indiana, Kentucky Association of Health Care Facilities (KAHCF) and Health Facilities Association of Maryland (HFAM). However, the competency-based role requirement needs more attention. Specific training will benefit facilities in attempting to not only meet the requirement, but to truly improve quality nursing care determined to improve high quality person-centered care. A competency-based approach to role assessment is the focus of this project.

Project Summary: The project is specifically designed to develop and implement a train-the-trainer certification series for nursing facility leadership, i.e. MDS Coordinators, Staff Development Coordinators, and/or Directors of Nursing. Participants will gain the skills needed to design, implement, and assess their own individual nursing facility competency-based training program in order to serve the care needs of their resident population.

The project developed by [Proactive Medical Review (PMR)](#) will consist of two consecutive days of in-person training on designing and implementing a competency-based program in a nursing facility. The initial two-day training is followed by a 90-day practice implementation period during which the participants return to their facilities and implement at least one competency program area for the nursing staff. Additionally, an individual one-hour consultation call will be provided to each participating facility during the 90- day practice implementation period, with a PMR consultant, to assist with each participating facility's program development and implementation. During the 90-day period, there will be twelve on-demand training webinars offered on twelve competency topic areas, of which a minimum of three must be completed. The competency webinars are accompanied by a train-the-trainer resource toolkit for each topic focused on a specific quality risk area intended to provide expert guidance on the design and implementation of staff competency development in the facility. Webinar/toolkit topics include:
- Abuse Prevention and Reporting
- Activities of Daily Living (ADL)
- Behavioral Health/Person Centered Care through Non-Pharmacological Approaches
- Cultural Competency
- Dementia Care
- Fall Prevention & Response
- Identifying Changes in Condition
- Infection Control/Prevention Basics
- Medication Administration
- Pressure Ulcer Prevention
- Restorative Nursing
- Trauma Informed Care.

Each webinar includes training on the designated topic and a review of best practices for implementing competency-based staff development program in that area and is followed by a post test. Each toolkit includes staff development resources including but not limited to PowerPoint slides and a quick reference inservice handout, instructor guidance, a competency assessment tool and posttest. Participants will select at least one of these topics to implement in the facility during this phase of the project based on their specific needs and risks. A risk prioritization guide will be provided as a resource to participants. A self-assessment will be completed following implementation of the initial competency module to identify performance improvement opportunities, needs and potential barriers to success.

An additional day of in-person training is required following the 90-day practice implementation period. The final day of in-person training is focused on reviewing best practices, implementation processes, sharing project outcomes, group discussion regarding overcoming barriers, and review of the self- assessment of their learning and project development. A final test is taken, which must be passed at 80% in order to receive the competency Train-the-Trainer Certification.

The competency program training process is designed to provide a sustainable program for each facility, as the participants reaching certification are then able to train others in their nursing facility and continue to develop their competency-based training program with the facility nursing staff and other team members as applicable to training topics and job roles. The plan is to provide the training in four Ohio cities geographically distributed to reach as many facilities as possible: Cincinnati, Columbus, Cleveland, and Lima. Up to 80 facilities will be recruited to participate in the program, with a goal of at least 40 facilities achieving certification following completion of the entire program. Competency Toolkits, access to on-demand webinars and sustainability activities including follow up contact with PMR consultant trainers in the year following the live workshops will promote long term success in implementing learned skills and ongoing program development in participating facilities.

Prior Success Data and Nursing Facility Interest in Program Participation

PMR delivered a Staff Competency Program workshop in August 2018 through Kentucky Association of Healthcare Facilities (KAHCF) which focused on developing the skills of nursing facility staff development coordinators. KAHCF collected participant evaluations of workshop presenter Shelly Maffia. Findings included: 100% of respondents agreed or strongly agreed that (1) the speaker was well prepared, articulate and interesting, (2) that they would attend another seminar by the speaker, (3) that the course met expectations, (4) the course increased knowledge as a provider and (5) was pertinent to needs, (6) that the subject matter was well covered, and that (7) handouts were well prepared and enhanced the program. The full workshop evaluation summary is included as Appendix H.

PMR has developed Competency Tool-Kits in the past for use in nursing facilities. A survey was conducted in August 2019 requesting feedback on satisfaction with these tool-kits including factors such as time saved in developing competency tools in-house, clinical quality, ease of use and the level to which the tools impacted competency related survey outcomes. 83% of respondents were extremely satisfied and agreed that the tool(s) filled a facility need and helped to improve the competency-based staff training program, 17% were satisfied and found the tool(s) were sufficient to supplement current competency-based staff training program. 100% of respondents rated their experience with PMR toolkits as Excellent or Good. The full survey report is included as Appendix I.

Data was collected in August 2019 regarding potential interest in participating in the Nursing Facility Competency Certification Program. Facilities expressed interest in the program by registering to receive more information, once available, in response to an article posted in the Ohio Health Care Association (OHCA) newsletter. As of August 21, 2019, twenty-two (22) nursing facilities have specifically expressed interest. The full listing of contacts expressing interest is included as Appendix J.   In addition, the following nursing facilities have returned letters of commitment regarding their interest in implementing the

program should it be approved:

- Crystal Care Nursing and Rehabilitation Center- Mansfield, OH
- Mercy Health Assumption Village- North Lima, OH
- Mercy Health Humility House- Austintown, OH
- Overbrook Rehabilitation Center-Middleport, OH
- Scarlet Oaks Community-Cincinnati, OH
- Stow Glen Retirement Village-Stow, OH
- Swanton Health Care and Retirement Center-Swanton, OH
- Ursuline Center of Toledo-Toledo, OH
- Windsor House-Girard, OH

The letters of commitment are included as Addendum K.

Project Plan and Timeline

Project development will start after the CMP grant is approved and will require approximately 485 hours of Consultant time to develop training, toolkits and supplemental resources and testing materials. The development phase would be completed in approximately twenty weeks. Nursing facilities will be recruited statewide, and recruitment will be accomplished via a campaign to solicit facility participation which may include: email announcements through Constant Contact™, Ohio Healthcare Association (OHCA) newsletter announcements, OHCA and PMR website postings, printed flyers accessible to attendees at OHCA conference/ live events, and social media posts targeting Ohio nursing facilities.   The facility training portion of the project is planned to span a timeframe of approximately seven months (depending on location).

In Table 1 on the following page, a sample timeline is outlined for project implementation including content development, facility solicitation to participate, scheduled trainings both in person and via webinar, and facility support and sustainability activities. Final certification for participants would occur approximately one year after project implementation (8 months after the initial live training session).

Project Coordinator
A project coordinator will assist with administration of the program. Duties include, but are not limited to: project management, venue planning, facilitating communication between program participants and PMR, printing/binding handouts, distribution of materials, webinar logistics coordination, maintaining training registration, on-site program training management and logistics, CE approval applications, scoring certification and webinar tests, issuing CE certificates, data collection, scheduling training events and facility conference calls, distributing and tallying satisfaction surveys, coordinating Constant Contact™ email communications, maintaining budget information and accounting, and other clerical tasks as required. Project Coordinator time required is estimated at 60 hours/month x 12 months, then 20 hours/month x 13 months at $25.00 per hour.

Table 1: Sample Project Timeline December 2019-December 2021

Date	Development & Administrative Activities		Training Activities	Support & Sustainability Activities
Dec. 2019	Training Content & Resource Development			
Jan. 2020				
Feb. 2020		Solicit Participation; Event planning		
Mar. 2020				
Apr. 2020				
May. 2020	CE approval confirmation		**2-Day Workshops** (12 contact hours) in 4 Locations -Competency Based Workshop -Competency Topic -Break Out Sessions -Group Practice -Workshop Evaluation	
Jun. 2020				
July 2020			**90-day practice implementation period**: -Complete at least 3 self-study webinar modules -Implement minimum of one priority module in facility based on facility risk prioritization guide -Conduct monitoring -Complete self-assessment with program goal setting	Group Q&A Session Conference Call
Aug. 2020	Competency testing development Final live workshop content development			Individual facility phone consultation to review priority module implementation progress, self-assessment and facility goals
Sept. 2020				
Oct. 2020			**Final Live Workshop** (4 contact hours) In 4 locations -Program & process review -Project sharing/ lessons learned & best practices -Overcoming barriers -Consumer Guide on Competency Based Training -Certification Testing -Workshop Evaluation + **Certification Testing** in 4 locations	
Nov. 2020	Prepare reporting on training/certification outcomes			
Dec. 2020	Quarterly review of health inspection outcomes for participating facilities		Issue Certificates/CE Credits	**Sustainability Tasks: Dec.2020-Dec.2021:** Monthly group email with program guidance(ie. job descriptions, monitoring, training tips)
Jan. 2021- Nov. 2021			Open Satisfaction Survey for Program Assessment via Survey Monkey	
Dec. 2021- June 2022	Final Reporting on outcomes Dec. 2021- January 2022			Facility assessment review & training plan for competency gaps; monitoring activity review Follow up consultation phone call with facilities with survey deficiencies in staff training/competency areas **Sustainability Tasks Jan.2021-June 2022** ongoing access to webinars available through June *2022*)

Content Development and Resource Allocation

Project specifics to be completed by PMR include development of actual content for both the in-person trainings and webinars, post-training testing, handout material development, updates and/or new development of competency tool kits for critical clinical topic areas, and graphic artist formatting of training handouts, toolkits, and webinars. A project coordinator will serve as project manager. Estimated hours of training content development by a consultant team made up of Registered Nurses, Physical and Occupational Therapists, and consulting activities to promote achievement of project goals includes, but is not limited to:

- 10 hours of training content development by PMR consultant for each hour of training content. 16 hours total over 3 days of live workshop + 12 hours of webinar training = 28 hours x 10 hours
  = **280 hours**
- Actual training presentation time (16 hours of live workshop training presented in 4 locations by 2 trainers = 144 hours; 12 webinars presented one time=12 hours
  =156 hours
- Individual facility phone consult July-Sept. 2020; Q&A support activities
  =**61 hours**
- Development of twelve competency program area toolkits & supplemental facility resources (see table 3 for details)
  =**184 hours**
- Development of Competency Certification Test (10 hours), CE course descriptions (3.5 hours), 12 Webinar Module post-test development, (3 hours), Participant checklist of certification requirements (1.5 hours), Program Satisfaction Survey (3)
  = **21 hours**
- Sustainability activities to be conducted to drive successful application of the program include: Quarterly review health inspection outcomes (5), Facility Assessment review (80 hours), Monthly Group Communication /Support Emails x 13 months via Constant Contact™ (13 hours), Follow up calls when deficiencies cited (10 hours) (see Table 4 for details)
  = **108 hours**
- Reporting activities (see table 5 for details)
  = **56 hours**

Trainings will be submitted for Continuing Education (CE) approval to the Ohio Nurses Association (http://ohnurses.org/education/#activityapproval).

Table 2: Estimate of CE Fees

Training	Contact Hours	Fee Per Session	Total Fee Estimated
2 day live training	12	$300.00	$300.00
1 day live training	4	$125.00	$125.00
One hour webinars (12 sessions to be offered)	12	$ 75.00	$900.00
	28		$1325.00

Participant resources to be delivered include **handout/training materials** for all participants, **post-tests**, and **certification test results**. **Certificates of attendance** will be provided as well as certification testing results confirmation. **Recordings of webinars** will be hosted on GoTo™ Webinar and will be accessible for future use by attendees for one year after the final day of in-person training through December 2021. **Twelve Competency Toolkits** for each focus competency area listed in the table below will be provided to participants for ongoing use in the facility in electronic format with permission granted to reprint and edit templates for internal education purposes. See Table 3 below for a complete listing of Toolkits and other participant deliverables provided to program participants with estimated development time for each resource.

Table 3: Competency Toolkits & Estimated Development Time Required

Development Time in Hours	Competency Toolkits	
20	Abuse Prevention & Reporting	Each Toolkit Contains: • Editable PowerPoint™ Slides • Instructor Guidance • Handouts • Pre- & Post Tests • Case Study and/or Relevant Training Application Resource • Competency Evaluation Form
6	ADL Care	
15	Behavioral Health & Person-Centered Care	
6	Cultural Competency	
20	Fall Prevention & Management	
6	Identifying Changes in Condition	
6	Infection Control & Prevention Basics	
20	Medication Administration	
20	Pressure Ulcer Prevention	
6	Restorative Nursing Services	
6	Trauma Informed Care	
20	Dementia Care	
Other Deliverable Resources Provided to Participants		
8	Basic Nursing Skills Workbook	Editable Excel workbook including orientation and training checklist and 35 individual competency forms for evaluating a range of basic nursing skills
4	SNF/NF Staff & Department Specific Competency Template	Editable Excel listing of minimum required competencies by department with suggested forms of validation, position specific listing of minimum required competencies and tracking of level of competence achieved
2	Competency Assessment Policy & Procedure Template	Editable policy and procedure template
8	Consumer Guide on Competency Based Training	Booklet for use as communication resource for residents, resident representatives and other consumers on competency-based training programs
4	Risk Prioritization Guide	Decision guide to be used as a tool when prioritizing competency topics to implement in the facility based on specific risks, quality improvement opportunities and goals.
4	Competency Program Self-Assessment Tool	Evaluation of facility specific competency-based training program performance improvement opportunities, needs assessment, barriers to success and identification of strategies to overcome barriers, as well as facility assets to guide goal setting and prioritization of program activities. Tool includes questionnaire/ summary report on roll-out of a minimum of one module in the facility with analysis of implementation.
3	Competency Program Certification checklist	Checklist of requirements/minimum standards and task completion listing to meet the standards for competency program certification
184		

Sustainability

Sustainability after the training portion of the project concludes will be fostered through implementation of a train-the- trainer education framework, take-away resources provided to ease the provider burden of facility inservice education, and follow up communication with PMR to promote ongoing, continued use of the competency-based program. PowerPoint presentations, post-tests, competency assessment tools, a facility policy/procedure template, and other resources will be shared for ongoing use as supplements to the live and webinar trainings provided to participants. Competency webinars will be accessible through June 2022 at a minimum, and may be referenced by Trainers as part of their ongoing implementation of the program with facility staff. Regular communication will continue in follow up to the live training events via monthly group email news with competency program guidance on topics such as updating job descriptions to include competency requirements, competency monitoring activity highlights, and training tips. Prior to each participating facility's survey window, PMR will review each participating facility's facility assessment & training plan for competency gaps and provide written feedback. Follow up consultation phone calls will be offered to those participating facilities with survey deficiencies in staff training/competency areas during the review period of December 2020-November 2021 to offer guidance on corrective actions.

Table 4.0 Support Activity Summary

Time in hours	Support Activities During 90 Day Practice Implementation Period
1 hours	Group Q&A Session Conference Call
60 hours	Individual facility phone consultation re: module implementation, progress update and self-assessment completion (45 mins each facility x 80 facilities)
61 hours	

Table 4.1: Sustainability Activity Summary

Time in hours	Sustainability Activities
80 hours	Facility Assessment review
13 hours	13 months of communication/support emails via Constant Contact ™
5 hours	Quarterly review of health inspection outcomes for participating facilities with follow up Nursing Home Compare reports reviewed when F726 cited
10 hours	Follow up phone/web meeting consultation should participating facility receive survey deficiency F726
108 hours	

Should the project prove successful, PMR is available to repeat the project offering in future years to additional staff.

Reporting

PMR will submit **quarterly progress reports** beginning April 2020 for the first quarter project period to the Ohio Department of Medicaid that will summarize work completed, deliverables produced, and any metrics collected for the project period, including but not limited to, attendance reports, training outcomes summary information, workshop evaluation survey data, and sustainability activities completed.

Beginning in October 2020 and continuing through September 2021, survey data for participating facilities will be reviewed through the Quality, Certification and Oversight Reports (QCOR) Application to identify F726 citations, and quarterly reports will include summary information on health inspection outcomes for F726 for participating facilities in comparison to state and national averages. A **final report** will be submitted in January 2022 which will analyze overall outcomes, summarize data for key metrics and assess project results including lessons learned. Key metrics for project reporting will include: F726 survey citations, program satisfaction, identification of appropriate solution to overcome competency program barrier(s), and program completion.

Table 5: Reporting Time

Time in hours	Reports to be completed
40 hours	8 quarterly reports to include project period summary information. F726 metrics included beginning with the period December 2020 through December 2021 to include metrics for all facilities completing the program
16 hours	Final project report
56 hours	

2. Expected Outcomes

The expected outcomes of this project are:
   A. A 25% reduction in F726 Competent Nursing Staff citations for each participating facility and in the statewide aggregate for all participating facilities.
   B. 80% of Participants will identify at least one solution to overcome an identified barrier to competency program success per the facility performance self-assessment.
   C. At least 85% of all participants will rate their satisfaction via workshop evaluation given after each live training event, rating the program as good or excellent in the following areas:
      a. Learning objectives were met.
      b. Appropriateness of content to nursing facilities.
      c. Usefulness of the knowledge/skills acquired.
      d. Value of the tools, resources and materials in implementing an improved competency assessment/training program.
   D. A minimum of 40 participants will complete all portions of the program and achieve Train-the-Trainer Certification as determined by completing the Competency Program Certification checklist and a passing score of at least 80% on the Final Certification Test.
   E. At least 40 participants will successfully complete a minimum of 3 of 6 online competency webinar modules via GoTo™ Webinar on-demand training links as demonstrated by attendance verification reports available through the webinar platform and a score of 80% or higher on each module post-test.

3. Results Measurement

A. The baseline measurement of F726 citations from annual and complaint surveys will be made by establishing the number of citations for participating facilities in the 12-month period prior to the program start date. PMR then will perform follow-up assessments of the number of F726 citations on a quarterly basis for a period of one year for facilities completing the program with a Train the Trainer certification, and will compare quarterly data to baseline data.

B. 80% of Participants will identify at least one solution to overcome an identified barrier to competency program success per the facility performance self-assessment. The self-assessment data will be collected via a pdf fill-in questionnaire which evaluates facility specific competency-based training program performance improvement opportunities, facility needs assessment, barriers to competency program success and identification of strategies to overcome barriers, as well as facility assets to guide goal setting and prioritization of program activities. The questionnaire will include reporting on the initial roll-out of a minimum of one module in the facility with analysis of the success/barriers of implementation.

C. Participants will rate their satisfaction with the program using a workshop evaluation completed after day 2 of the initial 2-day live workshop event and again via workshop evaluation following the final live workshop event.

D. To achieve the certification, all participants must have completed all portions of the program and designed and implemented at least one role-based competency in their facility. Completion of all program components will be facilitated via phone contact and meeting opportunities offered during the 90-day practice implementation period. Successful achievement will be measured via 100% completion of items on the Competency Program Certification Checklist, completion of the Competency Program Self-assessment, and a passing score of at least 80% on the Final Certification Test.

E. At least 40 participants will successfully complete a minimum of 3 of 6 online competency webinar modules via GoTo™ Webinar on-demand training links as demonstrated by attendance verification reports available through the webinar platform and a score of 80% or higher on each module post-test. Webinar module post tests will be administered via GoTo™ webinar, scored by PMR and continuing education certificates issued upon successful completion.

4. Benefit to Nursing Home Residents

Nursing home residents will benefit when the staff in their facilities receive the competency-based training provided by this project because the training they receive will enable staff to provide better care to residents, thus improving resident health and psychosocial well-being.

5. Non-Supplanting

This project will not supplant existing responsibilities of the nursing home to meet existing Medicare/Medicaid requirements or other statutory and regulatory requirements. Instead, the project will provide user-friendly tools, resources and education to advance compliance with competency-based training requirements for efficient and sustainable adherence to regulations.

6. Consumer and Other Stakeholder Involvement

Nursing facility staff will be involved in the implementation of this project when they participate in the in-person and webinar trainings that will be offered. Each participating staff person will receive a Competency Toolkit and numerous other resources for training purposes and will complete a pre-test and a post-test to assess the effectiveness of the training they receive. Following training, staff will use the improved direct care skills they acquire to provide better care for residents in the facilities in which they work. Staff will continue to be involved after the project period concludes when they use the on-demand webinar resources that PMR will continue to make available through June 2022. Residents are involved to the extent they receive better care resulting from the competency-based training provided by this project.

7. Funding

Total funding requested: $268,071.95
Total non-CMP funds received for this project: $0
Note: Fees to cover food/beverage costs for live training events may be charged to participants at registration, but are estimated to be less than $75.00/attendee total for three days of training
Project duration: 31 months

Table 6: Budget Details

Development Costs	Number of hours	Cost/hour	Labor cost
Development of 16 hours of in-person training content & 12 hours of webinars; estimate 10 hours of development for each hour of live training. (completed by RN and/or PT/OT Consultant)	280	$185.00	$51,800.00
Develop 12 competency program area toolkits & supplemental facility implementation resources (Completed by RN and/or PT/OT Consultant)	184	$185.00	$34,040.00
Development testing for Competency Certification, Webinar modules, course descriptions for CE approvals (Completed by RN and/or PT/OT Consultant), satisfaction survey	21	$185.00	$3,885.00
Total Development Costs			**$89,725.00**
Training /Certification Program Expenses			
Ohio Nursing CE Approval	Up to 28 contact hours available to participants	Cost detailed table 2	$1,325.00
Meeting Space Rental: Average of 4 Venue Cities x 3 days	Venue Fees Each Site	Total Days In-Person Training	Total Venue Fee
Columbus, Cleveland, Lima, and Cincinnati Avg Room Fee	$500	12 days	$6,000.00
Travel for Trainings: driving (miles calculated to/ from Evansville, IN)	Miles (Round Trip x2 trips based on 2 workshop dates)	Cost per mile	Mileage cost
Cincinnati, x2 trips, one way is 217 miles	868	0.55	$477.40
Cleveland, x2 trips, one way is 465 miles	1,860	0.55	$1023.00
Columbus, x2 trips, one way is 319 miles	1,276	0.55	$701.80
Lima, x2 trips, one way is 344 miles	1,376	0.55	$756.80
Project Coordinator travel	1,349	0.55	$741.95
Overnight Rooms			
Trainer Overnight Rooms, x3 nights x2 trainers x 4 venues	$120	24	$2,880.00

Project Coordinator Overnight Room, x3 nights x1 project coordinator x 4 venues	$120	12	$1,440.00
Webinar Hosting	Cost per month	Months	
GoTo™ Webinar Hosting Platform	$199/mo	24 months	$4776.00
Deliverables	# Attendees	Cost/item	
Handout Material cost 120 pages per attendee Est: $7.49/ream of paper, $3/binder 2", printing cost Cost per page=.0458 cents per page bound	80	$5.50	$440.00
Toolkits: 12 editable toolkits in e-Form at @ $49/each with permission for ongoing use single facility (*similar toolkits are $89/each in PMR store*)	80	$588	$47,040.00
Basic Nursing Skills editable Excel workbook @ $99/each (*similar item $199 in PMR store*)	80	$99	$7,920.00
SNF/NF Staff & Department Specific Competency Template	80	$69	$5,520.00
Competency Assessment Policy & Procedure Template with permission for single facility use and edits (similar policies are $69 in PMR store)	80	$29	$2,320.00
Trainer/Other Labor Costs	Number of Hours	Cost/hour	
Project Coordinator 60 hours/mo. x 12 mo. then 20 hours/mo. x 13 mo.	980	$25	$24,500.00
2 Trainers per in-person training for 16 contact hours over 3 days + testing time 2 hours x 4 venues (18hrs x 2 trainers= 36 hours x 4 venues = 144 hours)	144	$185	$26, 640.00
1 Trainer per webinar for 12 contact hours	12	$185	$2,220.00
Total Training Costs			**$136,721.95**
Support Activities *as detailed table 4.0*	61	$185	**$11,285.00**
Sustainability Activities *as detailed table 4.1*	108	$185	**$19,980.00**
Reporting Activities *as detailed table 5*	56	$185	**$10,360.00**
Total Funding Requested			**$268,071.95**

See Addendum G for a summary of the budget allocation by fiscal year.

8. Involved Organizations

Proactive Medical Review
2207 Morgan Ave., Suite D
Evansville, IN 47711
http://www.proactivemedicalreview.com/.

Proactive Medical Review, LLC (PMR) will carry out and be responsible for the project. PMR will receive funds through this project.

PMR began operations in 2011 with the mission of serving post-acute care providers through regulatory and reimbursement compliance training and consulting services. Amie Martin is the President of the company. Amie developed the company into a premier post-acute care consulting firm with an interdisciplinary team of six consultants providing services related to compliance consulting and training, interim compliance officer services, clinical documentation

and coding audits, and targeted training for clinical quality, QAPI, reimbursement accuracy, and quality assurance programming. Amie's CV is included in Appendix A. PMR is frequently invited to provide many state level and organizational presentations on a variety of clinical and regulatory compliance topics as well as individual facility level consulting, training and intervention planning.

9. Contacts

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Shelly Maffia, Director of Regulatory Services
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References

Centers for Medicare & Medicaid Services (CMS) (2016). Medicare and Medicaid; reform of requirements for long-term care facilities. 81 FR 68688. Retrieved from https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities

Appendices

- Appendix A – Amie Martin CV
- Appendix B – PMR Reference List & W-9
- Appendix C – PMR Sample Training Brochures
- Appendix D – PMR Sample Toolkit
- Appendix E – PMR Sample Policy
- Appendix F – Participant Evaluation/Satisfaction Questionnaire
- Appendix G – Budget by Fiscal Year
- Appendix H - KAHCF Speaker Evaluation Summary
- Appendix I - Competency Tool-Kit Satisfaction Survey
- Appendix J - Interested Nursing Facility Contact List
- Appendix K- Letters of Commitment

Appendix A

Amie Ryan Martin, OTR/L CHC, VDT-CT, RAC-CT

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Evansville, IN 47711

(812) 431-4804

QUALIFICATIONS

Outcome driven Clinical Consultant, Medical Review expert, and healthcare operations executive with over twenty years of experience serving in post-acute care as a clinical program specialist and in leadership positions. Currently certified in healthcare compliance, with a record of successfully partnering with post-acute care providers and rehabilitation contractors to improve regulatory compliance, 5-star quality, clinical programs, clinical documentation and reduce claim error rates under medical review. Certified Resident Assessment Coordinator through the American Association of Nurse Assessment Coordination (AANAC), with a strong background in Skilled Nursing Facility (SNF) Prospective Payment System (PPS) reimbursement and rehabilitation RUG supportive documentation requirements. Extensive experience consulting with SNF and outpatient therapy providers undergoing reimbursement audit types including UPIC, ZPIC, RAC, MAC, CERT, and therapy manual medical review, as well as managed care and private insurance appeals.   Clinical program specialty areas include dementia care, behavioral health, antipsychotic/psychotropic medication reduction, falls prevention, weight loss, orthopedic rehabilitation, neurological rehabilitation, SNF QAPI, and discharge transitions for reduction in avoidable rehospitalizations. Experienced presenter and author for groups including the American Association of Nurse Assessment Coordination, American Health Lawyer Association, American Occupational Therapy Association, National Association of Rehabilitation Providers and Agencies, and the American College of Health Care Administrators. Engaged to conduct a 13-part clinical quality assurance performance improvement (QAPI)/5-Star webinar series in 2017 for American Health Care Association state affiliates in Indiana, Illinois, Kentucky, Maryland, Missouri, Nebraska, Ohio, Tennessee, and LeadingAge state affiliates in Indiana, Kentucky, California, Colorado, Oregon, Virginia, Florida, Rhode Island, and Washington.

WORK EXPERIENCE & SKILLS

2012-present

President Proactive Medical Review and Consulting

President, Partner, and Principal Consultant for firm specializing in post-acute care compliance, third party audit services, risk assessment, SNF/LTC QAPI programming, geriatric clinical program development, therapy management services, and medical review. Oversee ongoing QA audit, medical review, and/or regulatory compliance program services and projects for 200+ skilled nursing facilities and outpatient therapy centers. Serve as SNF and rehabilitation company interim compliance officer. Experience serving as a SNF reimbursement and therapy program expert witness. QAPI compliance consulting for hospital and SNF clients including 5-star rating enhancement guidance. Extensive teaching and speaking engagement schedule, as well as research and compliance program development responsibilities. Oversight of clinical consultant staff group and all company operations including preparation of budgets, financial reports, accounting, sales and marketing plans, and customer service.

2008-2012

Quality Assurance, Compliance and Medical Review

HTS Director of Quality Care Returned to position as HTS Director of Quality Care resuming responsibilities related to clinical programming, therapy related clinical consultation, QA, medical record documentation auditing, company wide training, as well as medical review management for over 100

nursing facilities. Supervised two full time clinical consultant assistants and reported directly to company owner/president. Developed and implemented formal clinical programs and staff training modules in the areas of HIPAA, Ethical Practice/Medicare Compliance, Abuse, Injury Prevention, Infection Control, SNF Falls Prevention, Dementia Care, Stroke Care, Cardiac Care, Wheelchair Positioning, Urinary Incontinence, ADLs, and Pain Management. Customized rehabilitation documentation software to facilitate supportive documentation compliance in consultation with national rehabilitation software programmer.

2007-2008

ProStep Rehabilitation Clinical Trainer

October 2007-January 2008, served as the Clinical Trainer for 80 long term care facilities throughout the Midwest, providing both in-person trainings and webinars to geriatric clinicians. Provided clinical consultation and quality review of SNF and rehabilitation processes as part of an elite five member national clinical rehabilitation expert team serving Extendicare corporation facilities, providing clinical & regulatory guidance and staff development. Served as editor of national clinical newsletter.

2004-2007

Program Development, Quality Assurance, & Clinical Staff Development

HTS Director of Quality Care, responsible for development and implementation of quality improvement programs company wide. Responsibilities included facilitating monthly clinical education for over 700 therapy staff, conducting QA reviews in skilled nursing facilities throughout IN and KY focusing on regulatory compliance, and new employee orientation, management training, and other education as indicated. Key accomplishments included:

- Developed interactive self-study compliance/annual training, covering HIPAA, abuse prevention, OSHA/infection control and safety, and documentation standards.
- Developed and implemented training to corporate and LTC facility staff on clinical programs such as dementia care, healthcare leadership, and depression in SNF residents, urinary incontinence, fall prevention, dining, restraint reduction, skilled services and supportive documentation, evidence based practice, and restorative nursing programs.
- Acted as primary clinical contact resource person for 100 long term care facilities and 700 therapists, offering clinical consultation, as well as Medicare claim trouble shooting.
- Corporate Compliance Committee Chair with primary responsibility for implementation and oversight of companywide quality assurance program.
- Developed customized clinical rehabilitation documentation templates with Accu-Med programmers.
- Updated internal clinical documentation audit and training programs to incorporate interrater reliability, clinical standards of care and high audit risk Medicare payment variables
- Managed all aspects of medical review and appeals for 100 contract sites including development of appeal processes, tracking systems, and training modules aimed at denial management and prevention. Implemented individual claim root cause analysis with follow up therapy staff education for quality improvement, and instituted corrective protocols and accepted written plans of correction for long term care facilities under progressive corrective action. Managed the Medicare appeals process A/ B denials and successfully represented providers during ALJ hearings for over 1000 Medicare claims between 2005 and 2013.

2003   **HTS Kentucky State Directo**r, promotion from Regional Director with responsibilities expanded to oversight of daily operations including budgets, staffing, quality care and customer service for over thirty KY contract therapy sites and supervising Kentucky Regional Directors.

2000   **HTS Regional Rehabilitation Director** managing multiple therapy site contracts for the Midwest based contract therapy provider, Healthcare Therapy Services. Management settings included multiple Indiana skilled nursing facilities, First Steps pediatric early intervention services, home health, assisted living facilities, outpatient, and community hospital contracts in a region covering approximately 25% of state

1996   <u>**Rehabilitation Department Manager**</u>, Occupational Therapist and clinical supervisor for Cross Country Travel Healthcare Agency, ATS rehabilitation and Mariner Corporation in various locations throughout rural North Carolina. Transferred internally in 1998 to serve as Rehabilitation Department Manager and Activity Director for a Mariner Corporation facility in Evansville, IN.

1994   <u>**Occupational Therapist**</u> providing direct services in rehabilitation settings including Inpatient Rehabilitation Facility (IRF) neurological rehabilitation team, outpatient, home health, sub-acute care, acute care and long-term care in Raleigh, NC and surrounding areas.

PROFESSIONAL WRITING

- 2017 Behavioral Health Updates article Hoosier Owners Providers for the Elderly (HOPE)

- December 2014 American College of Health Care Administrators KY newsletter <u>"Provider Oversight of Therapy Services: What's Your Plan?"</u>

- Spring 2013 AHLA (American Health Lawyer Association) Annual Conference Edition LTC-SIR Advisor "*<u>LTC Therapy Changes: Implications for Care & Reimbursement</u>*"

- March 2013 AANAC (American Association of Nurse Assessment Coordination) National Newsletter *<u>"Rehab Update 2013: What SNF Providers Need to Know"</u>*

- August 2012 Leading Age Indiana newsletter article " <u>Part B Therapy Caps Update</u>"

- August 2011 IN Healthcare Association newsletter article *"* <u>Preparing for Medical Review of Therapy Services</u>*"*

- March 2011 *American Occupational Therapy Association AMSIS national quarterly* <u>"Medical Review of Therapy Services: Preparedness and Response"</u>

- April, 2009 featured article *OT Advance Online* <u>"Therapy in a Garden Bed</u>*"*

- April, 2008 AOTA-*OT practice magazine* <u>"In Transit</u>*"*

- *Advance for OT* magazine article <u>"Sleep: The Forgotten ADL"</u> published August 20, 2007, Vol.23 No.17, reviewing therapeutic interventions to foster healthful sleep

- *Advance for OT* magazine article <u>"Individualizing Documentation"</u> published April 30, 2007, Vol.23 No.9, covering skilled therapy documentation and denial prevention for clinicians.

- April, 2007 AOTA-*OT practice* magazine <u>"Why I'm a Therapist"</u>

- March 2007 Featured as expert clinician for *Contemporary Long Term Care* March 2007 article on <u>"The Top Ten Reasons SNFs Lose</u> <u>Money,"</u> providing insight into issues regarding part B therapy, denials, and therapy contracts. www.cltcmag.com

RECENT PRESENTATIONS

2018   *Phase 3 Requirements of Participation for the Busy Administrator*
       Samaritan Alliance webinar August 3, 2018

       A Day in the Life of a Compliance Officer
       Indiana Health Care Association Annual Conference July 31, 2018

       Smarter Dementia Care: Non-Pharmacological Approaches
       Indiana Health Care Association Annual Conference August 1, 2018

2017   *Everyday Compliance: What Non-Profit Providers Should Know About Fraud Risk Mitigation*
       LeadingAge Indiana Pre-Conference September 25, 2017

       A Framework for Compliance with the Behavioral Health and Non-Pharmacological Approach Elements of Phase 2 RoP
       Management Advisors Group August 24, 2017

       ANPRM SNF PPS Update: RCS-1
       IHCA Annual Conference August 16, 2017

       Effective Care Planning
       IHCA DON Leadership training June 14, 2017

       Innovative Fall Prevention Strategies in LTC
       IHCA Spring Conference April 19, 2017

       13-part monthly webinar series: *Driving Five Star and SNF New Requirements of Participation*
       Multi-state affiliate AHCA/LeadingAge association engagement training projects
       http://www.proactivemedicalreview.com/driving-5-star-rop-implementation-through-a-qapi-approach-2017-webinar-series/

2016   *SNF Compliance for Board Members*
       KAHCF Annual Conference November 2017

       Lessons from the Headlines
       Co-presentation with David Bufford, Hall Render IHCA Annual Conference August 23, 2016

       A Compliance Focused Response to SNF PEPPER
       KAHCF Spring Conference April 26, 2016

       Preventing Common Behaviors and Antipsychotic Reduction System Wide Approaches
       Advanced Education Dementia for Indiana State Department of Health/University of Indianapolis
       Multiple dates and locations throughout Indiana

       12-part monthly webinar series: *QAPI in Action*
       IHCA, KAHCF, LeadingAge IN

2015   *Lessons Learned from ZPIC audits*
       NARA (National Association of Rehabilitation Agencies and Providers) Conference May 2015

       A Compliance Focused Response to SNF PEPPER
       Leading Age IN Reimbursement Day February 2015

2014   *Therapy Utilization Trends Under Scrutiny; Compliance Considerations for Rehab Ultra High &*
            Therapy Program Oversight
            KAHCF Fall Conference November 20, 2014

            Falls in LTC: Strategies that Work!
            3 CE Webinar Series October 2014

            Virtual Dementia Tour
            1 CE Hands On Learning Experience & Discussion Group in Multiple Skilled Nursing Facilities 2014

            Lessons Learned from a ZPIC
            KAHCF April 30, 2014 Spring Training Co-presentation with Marian Hayden, Esquire Cull &
            Hayden Law firm

            Common Medicare Denials and How to Avoid Them
            Indiana Leading Age May 5, 2014

2013   *Evidence based falls intervention planning for residents with dementia*
            KAHCF (KY Assoc. of Healthcare Facilities) Annual Conference Nov.12, 2013

            CMS Hand In Hand Abuse Prevention 6 Module Series and Virtual Dementia Tour Event
            Hopkinsville, KY November 2013

            Revisiting therapy-nursing maintenance programs for LTC residents in light of Jimmo v. Sebelius
            Leading Age Indiana Fall Conference September 2013

            SNF PEPPER reports and Compliance Programming
            Kentucky Association of Health Care Facilities Webinar September 13, 2013

            Preparing for Post-Acute Care Government Audits
            Presentation Indiana State Bar Association Healthcare Conference May 2013

            Preparing for Government Audits
            Presented Leading Age IN/HOPE spring conference May 2013

            Supporting Rehab RUG Levels through Interdisciplinary Documentation
            Presented National Conference of the American Association of Nurse Assessment Coordination
            May 2013

            Claims Based Reporting: What Providers Need to Know
            Seminar presented KAHCF (KY Assoc. of Healthcare Facilities) Spring Training April 16, 2013

            Practical Solutions for Rehab Dementia Care Series
            Guest Lecture Series University of Southern Indiana COTA Program March 2013

2012   *Supporting Rehab RUG levels through Interdisciplinary Documentation*
            Seminar presented Leading Age Indiana Fall Conference, Leading Age Kentucky Fall Conference,
            Indiana Healthcare Association Fall Conference, Kentucky Association of Healthcare Facilities fall
            conference

            Fresh Perspectives on Fall Prevention
            Webinar presentation March 2012 Kentucky Association of Healthcare Facilities

2011   *Interdisciplinary Supportive Documentation*
                2.5-hour course approved for Indiana Health Facility Administrators presented multiple post-acute facility providers and Samaritan Alliance GPO

                Rehab Quality Clinical Programs
                Kentucky Leading Age Fall Conference October 2011

PROFESSIONAL MEMBERSHIPS & AFFILIATIONS
Member AHLA (American Health Lawyer Association,) HCCA (Healthcare Compliance Association) and certified in healthcare compliance 2012, AHIMA (American Health Information Management Association), KAHCF (KY Association of Healthcare Facilities), 2012-2017 serve on KAHCF Payment Committee, Indiana Healthcare Association 2013 serve on IHCA Clinical and Reimbursement Committees, Leading Age IN Membership Liaison and Reimbursement Committee, Leading Age Florida, Illinois Healthcare Association, Ohio Healthcare Association, Association of Nurse Assessment Coordinators (ANAAC), Association of Healthcare Auditors & Educators (AHCAE,) AOTA (American Occupational Therapy Association,) IOTA- geriatric SIS, Dementia Care Specialist Certified Instructor 2011, former NCOTA executive board membership chairperson, Alzheimer's Association affiliate, member National Stroke Association, Member IOTFC, Wheels for the World therapy team leader, volunteer Girl Scout Leader Troop 98 Rain-tree Council;

Guest Lecturer University of Southern Indiana Occupational Therapy Program 2012, 2013, 2014

EDUCATION
1994 Occupational Therapy **Indiana University**, Indianapolis, IN
Certified in Health Care Compliance-Health Care Compliance Association 2012
AANAC (Minimum Data Set) RAC-CT Certification 2013
2017-2018 Masters in Health Law (MJ) currently in progress Loyola University Chicago

RECENT PROFESSIONAL DEVELOPMENT
2018 AHLA-Long Term Care and the Law conference New Orleans, LA
2018 AHCA-PDPM Patient Driven Payment Model
2017 LeadingAge Compliance and Legal Considerations Arising from the New RoPs
2017 OMHA-MLN Improvements to the Medicare Appeals Process and Statistical Sampling
2017 IHCA Emergency Preparedness Training
2017 AANAC The New Survey Process for NAC
2017 OHCA Know Your Narrative: Using Quality Data to Market to Referral Sources
2016 AHLA Long Term Care and the Law Conference San Diego, CA
2016 LeadingAge Compliance Update
2016 AHCA Discharge to Community: Creating Seamless Transitions
2015 AHLA Long Term Care and the Law Conference New Orleans, LA
2015 LeadingAge Compliance Update
2014 LEAN Six Sigma yellow belt certification course November, 2014
2014 HCCA Compliance Regional Meeting Louisville, KY November, 2014
2014 Upsurge in Privacy, HIPAA and HITECH Risks HCCA July 2014
2014 Resident Assessment Coordinator Certification Course June 2014
2014 Myers & Stauffer Medicaid Update April 2014
2014 Virtual Dementia Tour Certification January 2014
2013 AANAC 2014 MDS updates October 2013
2013 American College KY Rehab's Role in Preventing Re-Hospitalization September 2013
2013 CERT Task force webinar August 2013
2013 Leading Age Compliance Update July 2013
2013 Indiana Bar Association Health Law Conference May 2013
2013 OIG Work plan-KAHCF Spring Training April 17, 2013 Lexington, KY

2013 NARA Claims Based Functional Reporting
2013 HIPAA update and Data Breach Response Planning IHCA webinar February 5, 2013
2012 HCCA Compliance Certification Course San Antonio, TX
2012 AHLA Fraud & Abuse Conference Baltimore, MD
2011 Dementia Care Specialist Certification Course St. Louis, MO

Appendix B

Organization	Services Performed	Contact Name/Title	Email/Phone
Ohio Health Care Association (OHCA)	Member Training Live conference presentations and webinar training series engagements 2017-2019	Kathy Chapman, Education Director	55 Green Meadows Drive South | P.O. Box 447 | Lewis Center, OH 43035| Ph: 614.540.1321 direct kchapman@ohca.org
Kentucky Association of Health Care Facilities (KAHCF)	Member Training Live Workshops, training presentations and webinar training series engagements 2016-2019	Angela Porter, VP of Education	9403 Mill Brook Road Louisville, KY 40223 Ph: 502-425-5000, 306 aporter@kahcf.org
Indiana Health Care Association (IHCA)	Member Training Live Workshops, training presentations, pre-conference institutes and webinar training series engagements 2016-2019	Katie Niehoff, Director of Education & Member Services	One North Capitol, Suite 100 Indianapolis, IN 46204 Ph: 317.616.9028 direct kniehoff@ihca.org
LeadingAge Indiana	Member Training Live Workshops, training presentations and webinar training series engagements 2016-2019	Emilie Perkins, VP of Training	6280 West 96th Street Indianapolis, IN 46278 Ph: Phone: (317) 733-2380 eperkins@leadingageindiana.org

Proactive Medical Review & Consulting, LLC Training Engagement Reference List

Company	Services Performed	Contact Name/Title	Email/Phone
Healthcare Therapy Services 1411 W. County Line Rd. Suite A Greenwood, IN 46142	Quality assurance consulting for approximately 200 SNF/NF and outpatient therapy facilities as subcontractor through rehabilitation vendor. Services include 1000 annual medical record QA audits, medical review/appeals management, QA work plan development, monthly reporting, and consulting services related to Medicare compliance and rehab skilled services.	Christine Kroll Director of Operations	ckroll@htstherapy.com 800-486-4449 x210
Cascade Health Services, LLC 5040 Champion Drive Lufkin, TX 75901	SNF/NF provider group consulting for staff development, clinical programming and Medicare compliance	Gwendolyn Reeves Compliance Officer	gwenlynn.reeves@gmail.com 469-241-9722
Good Samaritan Home, Inc. 601 N. Boeke Rd. Evansville, IN 47711	Medical review consulting & dementia care staff development services for 200+ bed post-acute care facility	Kenneth Karmire Dir. of Risk Management, CCO	kkarmire@goodsamhome.org 812 759-0496
Maple Manor Christian Home 643 West Utica Street Sellersburg, Indiana 47172	Medical review consulting services for post-acute care facility	Jacqueline Pike Director of Nursing	j.pike@maplemanorchristianhome.org 812-246-4866
Parkway Medical Center 1155 Eastern Parkway Louisville, KY 40217	Quality assurance consulting including staff development and clinical auditing/monitoring; Reimbursement and medical review consulting	Rick Foley CFO, Owner	pmcrickfoley@yahoo.com 502-636-5241
St. Anthony Health & Rehabilitation 1205 N. 14th St. West Lafayette, IN	Consulting for Medicare compliance, rehabilitation services, medical review, CMI and skilled nursing facility service programming	Ken Thompson, Administrator	admin@sahc.net 765-423-4541
Nazareth Home 2000 Newburg Rd. Louisville, KY 40205	Consulting for Medicare compliance, medical review response and appeals management	Mary Haynes CEO	mhaynes@nazhome.org 502-459-9681

Form W-9
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer
Identification Number and Certification

▶ Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give Form to the requester. Do not send to the IRS.

---

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

Proactive Medical Review and Consulting, LLC

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☑ Partnership ☐ Trust/estate

☑ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

2207 E. Morgan Avenue, Suite D

6 City, state, and ZIP code

Evansville, IN 47711

7 List account number(s) here (optional)

Requester's name and address (optional)

Part I   Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

| | | | – | | | – | | | | |

or

Employer identification number

| 4 | 5 | – | 2 | 7 | 8 | 6 | 5 | 0 | 2 |

Part II   Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here | Signature of U.S. person ▶ *[signature]* | Date ▶ 1/19/19

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

• Form 1099-INT (interest earned or paid)

• Form 1099-DIV (dividends, including those from stocks or mutual funds)

• Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)

• Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)

• Form 1099-S (proceeds from real estate transactions)

• Form 1099-K (merchant card and third party network transactions)

• Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)

• Form 1099-C (canceled debt)

• Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, later.

Cat. No. 10231X

Form **W-9** (Rev. 10-2018)

Appendix C

2018 Webinars:
Mastering Regulations, Red Tape & Resident Care

F-Tag Review Series
Comprehensive Review of Regulations & Interpretive Guidance for Top F-Tags
A series of 12 webinars focusing on top-cited F-Tags in the new survey process

During this year long series, we will focus on the top deficiencies cited nationally with the new Long Term Care Survey Process (LTCSP). Each session will concentrate on top-cited F-Tags with a review of the regulation and an analysis of the associated Interpretive Guidance. Survey procedures, such as associated Critical Element Pathways and/or Surveyor Probes used to guide the investigative process will be discussed. Actual citation examples will be shared and examined. Tools to assist the facility interdisciplinary team in monitoring compliance and incorporating performance improvement activities into the facility QAPI processes will be a focal point.

Projected Learning Outcomes/Course Objectives:

- Identify the regulatory requirements related to the monthly F-Tag topic
- Identify survey procedures that describe how the F-Tag topic is reviewed for compliance during the annual survey process
- Identify examples of how the F-Tag is commonly cited in the new LTCSP
- Identify tools for the leadership team to use for monitoring compliance with the F-Tag topic
- Explain strategies for incorporating survey preparedness into facility QAPI processes

Course Content:

1. Overview of the F-Tag Regulations and Interpretive Guidance
2. Survey procedures for assessing compliance with the F-Tag and citation examples
3. Strategies for monitoring compliance and incorporating survey preparedness into facility QAPI processes
4. Closing Comments/Q&A

See association registration page for member or non-member pricing.

LeadingAge Colorado   LeadingAge Connecticut   LeadingAge Florida   LeadingAge Indiana   LeadingAge Iowa   LeadingAge Virginia   LeadingAge Washington

Based on the most commonly cited F-Tags with the new long term care survey process, the monthly F-Tag topics will be:

January 31	Infection Control/Antibiotic Stewardship F880, F881 (Former F441)
February 28	Food Safety F812, F813 (Former F371)
March 28	Accidents/Bed Rails F689, F700 (Former F323)
April 25	Quality of Life/Quality of Care F675, F684, F697, F698, F744 (Former F309)
May 30	Pharmacy Services F755, F761 (Former F431)
June 27	Comprehensive Care Plans F656 (Former F279) CP Timing & Revision F657 & Professional Standards F658
July 25	Unnecessary Drugs F757, F758 (Former F329)
August 29	ADL Care for Dependent Residents F677
September 26	Resident Assessments/Accuracy of Assessments F636-F642
October 31	Dignity and Respect of Individuality F550 (Former F241)
November 28	Treatment/Services to Prevent/Heal Pressure Ulcers F686 (Former F314)
December 19	Bowel/Bladder Incontinence, Catheter, UTI F690

All sessions begin at 3:00pm ET, 1:00pm MT, 12:00pm PT

Target Audience:
Director of Nursing, Assistant Director of Nursing, Nurse Managers, Nursing Home Administrators, Nursing Staff and Leaders, Quality Assurance Director, Social Services, Rehabilitation Services

Instructional Level: Intermediate

NAB Approved Contact Hours: 1.25 each
Check your state association registration page for details on additional CE accreditations.

Presenter Information:

Shelly Maffia, MSN, MBA, RN, LNHA, QCP
812-719-0452 | smaffia@proactivemedicalreview.com

Director of Regulatory Services for Proactive Medical Review & Consulting, with over 15 years of leadership and consulting experience, Shelly has held positions as DON, NHA, Corporate Nurse Consultant, and Training Positions. Currently Shelly provides consultation on regulatory compliance to nursing facilities in multiple states. Her expertise includes developing clinical training tools, policies, procedures, protocols and training programs on systems, processes and best practices. Shelly is also a QAPI Certified Professional (QCP) through the American Association of Nurse Assessment Coordinator.

PROACTIVE
MEDICAL REVIEW

Proactive Medical Review & Consulting assists post-acute care providers in ensuring compliance with regulatory standards and promoting measurable care excellence. Proactive specializes in SNF risk assessment, Quality Assurance Performance Improvement (QAPI) projects, medical record review services and staff development to promote care quality and effective clinical documentation. Proactive offers consulting for Medial Review and Medicare Appeals, and is uniquely positioned to assist SNF providers with therapy oversight and the defense of skilled rehab services through their team that includes Therapist consultants in addition to Nurse, Health Facility Administrator, MDS and SNF/NF billing experts.

Proactive Medical Review, LLC | (812) 471-7777 | www.proactivemedicalreview.com

Moving MOUNTAINS

PROACTIVE MEDICAL REVIEW

SNF Provider Training, Tools and Insight to Conquer 2019 Industry Changes

This webinar series will guide providers in implementing a step-wise action plan to manage the industry changes taking effect in 2019 including **Phase 3 RoP (Requirements of Participation)** and preparing for the reimbursement transition from Medicare PPS RUGs IV to the **Patient Driven Payment Model (PDPM)**. Plan to join us beginning September 4, 2018 for the first session in the series. Additional sessions may be added in the fall of 2019 based on member feedback and CMS updates.

NAB Approved Contact Hours: **1.25 each session**; check your state association registration page for details on additional CE accreditations

Target Audience: Director of Nursing, Assistant Director of Nursing, Nurse Manages, Nursing Home Administrators, Nursing Staff & Leaders, RAI Coordinator, QA Director, Social Services, Staff Development Coordinator, Rehabilitation Services, Board Members

All sessions held the first Tuesday of each month (except January 2019) at 1:30pm central/2:30pm eastern/9:30am HST

September 4, 2018	Phase 2 RoP: What We Have Learned; Strategies Based on Survey Deficiencies
October 2, 2018	Phase 3 RoP: What to Expect; Developing Your Facility Action Plan
	Topics below are subject to change pending SNF PPS Final Rule and CMS Interpretive Guidance related to Phase 3
November 6, 2018	PDPM: Understanding PDPM & Developing Your Facility Action Plan
December 4, 2018	Phase 3: Implementing an Effective QAPI Program
January 8, 2019	PDPM: Effective Systems and Coding of Section GG
February 5, 2019	Phase 3: Implementing an effective SNF Compliance & Ethics Program
March 5, 2019	SNF Quality Reporting (QRP) and SNF Value Based Purchasing (VBP) Programs
April 2, 2019	PDPM: Developing ICD.10 Expertise for Effective Coding of Clinical Categories & Non-Therapy Ancillary
May 7, 2019	Phase 3: Implementing Successful Staff Training & Competency Programs
June 4, 2019	PDPM: Rehab program transitions and provider insight for SNF PT, OT & SLP service reimbursement
July 2, 2019	Phase 3: Next Steps for the Infection Preventionist
August 6, 2019	Operational Strategies for Success Under PDPM (with expert panel)
September 3, 2019	Phase 3: Trauma Informed and Culturally Competent Care
October 1, 2019	TBD *based on CMS updates and identified transition issues*
November 5, 2019	TBD

See association education page to register for member or non-member pricing.

Presenter Information:

Amie Martin, OTR/L, CHC, RAC-CT
Clinical Consultant
amartin@proactivemedicalreview.com

Amie Martin is an Occupational Therapist and Compliance Officer with over twenty years of experience serving in long term care leadership positions and as a clinical program specialist. Amie is certified in healthcare compliance. She has successfully partnered with providers to develop and implement Compliance and Ethics Programs, achieve 5-star survey results, and ensure Medicare reimbursement accuracy as Founder and President of Proactive Medical Review Consulting.

Shelly Maffia, MSN, MBA, RN, LNHA, QCP
Director of Regulatory Services
smaffia@proactivemedicalreview.com

Director of Regulatory Services for Proactive Medical Review & Consulting, with over 15 years of leadership and consulting experience, Shelly has held positions as DON, NHA, Corporate Nurse Consultant, and Training Positions. Currently Shelly provides consultation on regulatory compliance to nursing facilities in multiple states. Her expertise includes developing clinical training tools, policies, procedures, protocols and training programs on systems, processes and best practices. Shelly is a QAPI Certified Professional (QCP) through the American Association of Nurse Assessment Coordinator and an AHIMA approved ICD-10 CM/PCS trainer.

Eleisha Wilkes RN, RAC-CT
Clinical Consultant
ewilkes@proactivemedicalreview.com

Eleisha Wilkes is a Registered Nurse with over fifteen years of experience in long term care. She has served as a Director of Nursing, Case Manager and Resident Assessment Coordinator with extensive responsibility and success in driving QA in the areas of person centered assessment and care planning through effective systems, staff development, and interdisciplinary team collaboration. She now serves as an RN Clinical Consultant with Proactive Medical Review & Consulting.

Proactive Medical Review & Consulting assists post-acute care providers in ensuring compliance with regulatory standards and promoting measurable care excellence. Proactive specializes in SNF risk assessment, Quality Assurance Performance Improvement (QAPI) projects, medical record review services and staff development to promote care quality and effective clinical documentation. Proactive offers consulting for Medial Review and Medicare Appeals, and is uniquely positioned to assist SNF providers with therapy oversight and the defense of skilled rehab services through their team that includes Therapist consultants in addition to Nurse, Health Facility Administrator, MDS and SNF/NF billing experts.

Appendix D

PROACTIVE

MEDICAL REVIEW

Competency Based Training & Assessment
Made Easy!

Identifying & Reporting Changes in Condition

This Tool-kit is intended to supplement or enhance current SNF/NF educational programs to meet the intent of the new requirements.

Introduction & Table of Contents

Due to revised Requirements of Participation (effective November, 28, 2017), facilities are now tasked with validating that each employee is competent in their role. **The State Operations Manual Appendix PP -Guidance to Surveyors for Long Term Care Facilities**, outlines the requirement at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

§483.35 Nursing Services

The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e)...

Furthermore,

...Competency may not be demonstrated simply by documenting that staff attended a training, listened to a lecture, or watched a video. A staff's ability to use and integrate the knowledge and skills that were the subject of the training, lecture or video must be assessed and evaluated by staff already determined to be competent in these skill areas. §483.35(a)(3)-(4),(c)

This Tool-kit is intended to supplement or enhance current SNF/NF educational programs to meet the intent of the new requirements.

Tool-Kit Table of Contents

This Tool Kit may be used with permission of Proactive Medical Review by a single purchasing facility and documents may be edited to customize based on this single purchasing facility's needs.

How to Use This Tool Kit

This competency may be reviewed based on facility policy, but is generally recommended for review with applicable employees upon hire, annually, and as needed when gaps in competency are identified.

This tool kit includes Case Studies which may be used to assess competency by performing group simulations, scenario discussions, or individual evaluations. The Participant Worksheet may be used to guide group discussions or as an individual evaluation of knowledge and ability. The Competency Evaluation form is best suited for small group role-play, but can be used as the facility sees fit.

Practical Applications

One way to identify gaps in competency related to identifying and reporting changes in condition is to monitor and review those residents who return to the hospital setting during their SNF stay. Review each hospitalization, including, but not limited to, the following information:

- Date of hospitalization
- Date change in condition was recognized
- Practitioner ordering transfer
- Staff on duty at time of transfer
- Hospital admitting diagnosis
- Laboratory and/or diagnostic testing that was performed in the SNF
- Contributing factors leading to transfer
- Whether the hospitalization could potentially have been prevented
- Summary of process changes and/or educational needs identified

Conclusions can then be reviewed and Performance Improvement action plans implemented by the Quality Assurance Performance Improvement (QAPI) team as indicated.

See the enclosed **Return to Hospital Review Tool** as a sample guide to ongoing facility-wide monitoring.

Lesson Plans & Instructor Guide for use with PowerPoint™ Presentations (for both licensed and non-licensed staff presentations)

A change in a resident's condition may indicate a resident is at risk. Action can be taken to reduce this risk only when those changes are promptly identified and reported. Changes that are not reported can lead to serious outcomes, including medical complications, transfer to a hospital, or even death.

To identify changes in condition and be confident in reporting them as needed, staff must understand what is normal (baseline) for a resident's condition when he or she first comes into the nursing center, and as their condition evolves over time. Armed with this information, staff will be able to identify changes and make appropriate decisions regarding which changes should be reported to others on the care team.

Presentation Format & Timing
Present the material using the power point slides and resources based on your facility needs.
Suggested training format:

- Orientation: Use the power point slides and instructor guidance below to train staff. Assess competencies through the case discussion on slide 5 and use of the pre &post tests
- Annual Training/Remediation Competency: Review the Participant Take Away Handout. Assess Competency using the Case Studies during a group discussion OR small group work study activity with the Participant Case Study Worksheet

The suggested timing for each part of the training session is:

Powerpoint Training + Activities	Time
Introduction of Instructor, Topic, & Objectives	*5 minutes*
Pre-test	*5 minutes*
Power Point Case Study and Discussion	*10 minutes*
Interactive Lecture	*15 minutes*
Review Key Take-Away Points, Question & Answer	*5 minutes*
Post-test	*5 minutes*

Interactive Lecture
With this method you present the material, using questions-and-answers and the provided PowerPoint™ slides. During your lecture, be sure to personalize the presentation as much as possible. For example, explain and describe what early warning tool your facility uses, and provide a sample copy of the tool with guidance on its use.

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Lesson Plans & Instructor Guide for use with PowerPoint™ Presentations (for both licensed and non-licensed staff presentations) *Continued...*

Case Discussion

Slide 5 Presenter Guidance

The case study on slide 5 tells a story. It involves situations similar to those faced by participants during their work. The presenter should lead a discussion that provides an opportunity to demonstrate what they know and how they might handle the situation. Facilitate participation so that different ideas are heard.

Probing questions you could ask to reinforce the knowledge you are sharing might be:
- Could you give an example of a warning sign that Ms. A was becoming more ill?
- Ordinarily, what is the result of treatment with an antibiotic for people with diarrhea?

Encourage critical thinking and communication with questions such as:
- At what point would you think that the diarrhea might be a symptom of something more serious?
- Who could you share these concerns with?
- What do you think Ms. A's nursing team might have done differently that could have prevented her condition from getting worse?

Slide 10 Presenter Guidance & Speaker Notes:

Refer to the Facility early warning tool and provide guidance on its use.

- Walking – e.g., the resident needs more assistance with walking; shuffling steps; loss of balance
- Urination and bowel patterns – e.g., the resident is urinating less frequently; new onset or worsening incontinence; constipation; diarrhea
- Skin – e.g., the resident's skin is puffy; new or worsening wound; local or body wide rash; dry, cracked lips
- Level of weakness – e.g., the resident is having difficulty lifting his or her arm; generalized weakness; new or worsening fatigue
- Falls risk– e.g., the resident reaches for objects when in a wheelchair; new or recently changed medications; potential sign of underlying illness
- Vital signs – e.g., the resident is breathing faster than normal; elevated blood pressure; decreased oxygen saturation
- Demeanor – e.g., the resident is socializing less than normal; inattentive; withdrawn
- Appetite – e.g., the resident is not interested in his or her food; skipping meals; nausea
- Sleeping – e.g., the resident falls asleep in unusual places; difficult to rouse from sleep; insomnia
- Speech – e.g., the resident's speech is slurred; trouble chewing and/or swallowing food
- Confusion or agitation – e.g., the resident is talking a lot more or less than usual; resistance to care
- Resident complains of pain – e.g., the resident grimaces or winces when he or she moves; verbal complaints of discomfort

Slide 20 (Licensed Staff version) Speaker Notes

Edit this slide as needed to reflect your facility's specific tool for communicating changes in condition and communicating with practitioners. You may provide a sample of these tools and review the process for each. Ask for feedback on current areas of opportunity for improving team communication related to changes in condition

Review Key Take-Home Points

- Promote a safe environment based on teamwork and thinking about how the system of care works and how it can be improved, rather than thinking about blame.
- Educate the entire staff about the importance of noticing changes, risk factors for residents, and methods of prevention.
- Use appropriate risk-assessment and reporting tools

PROACTIVE
MEDICAL REVIEW

Identifying and Reporting Changes in Condition

Competencies for the Post Acute Provider
for licensed staff

Introduction

- Most older adults have at least two or more chronic conditions, including diabetes, heart disease/stroke, and cancer. These conditions can lower quality of life, lead to a wide array of complications, and even shorten lifespans. Three of the most common chronic diseases seen in skilled nursing centers are diabetes, heart disease/stroke, and cancer. Common causes for hospital admissions for older adults include CHF, COPD, DM, infection, pneumonia, and stroke.

- Early detection and communication of changes in condition is imperative to assuring resident safety and attaining or maintaining the highest practicable physical, mental, and psychosocial well-being of each resident.

Licensed Nurses

- The provider who evaluates the change
- Assessment is one of their most important responsibilities
- Ask the resident how they feel, how symptoms began and when
- Obtain vital signs and perform a general exam and assessment
- Must communicate effectively to the practitioner
- Advocate for the resident; don't be afraid to voice concerns and request intervention
- Implement, communicate, and monitor interventions

Knowledge Objectives

Participants will be able to understand:

- Why detecting change is important
- How to know a residents normal (baseline) condition
- Assessing for change
- Effective use of the SBAR tool
- How and what to communicate about change
- Key principles of effective communication

Case Study

Ms. Smith, a 79-year-old woman, was admitted to SNF after a hip fracture. She walks with difficulty with a walker and needs help with ADLs. Ms. Smith also has several other medical problems including high blood pressure, diabetes, and arthritis, and is also being treated for depression. Her family visits regularly on weekends. She rarely participates in activities; at mealtimes she avoids conversation. Recently she had diarrhea, was incontinent of liquid stool, and nursing assistants had to change her adult briefs once or twice per shift. She began taking meals in her room. Stool tests showed that she had a bowel infection with Clostridium difficile. An antibiotic was started. Even with the antibiotic, her bowel movements continued to be liquid and frequent over the next week, and she was eating less. Her blood pressure had been normal for her, but her pulse rate was 90-100 yesterday, which was higher than her usual 70-75. Yesterday, she had a fever of 102.5 and was transferred to the acute hospital, where she was admitted to the Intensive Care Unit.

- How did Ms. Smith get so sick with only diarrhea?
- What symptoms might have been noticed sooner?
- When might you have decided to report it?
- What would you have reported to the physician?

Knowing the Resident's Baseline Condition

- Take time to get to know your residents
- Talk with team members, the resident, and their family/representative
- Actively participate in change of shift report
- Take note of the resident's ability to move around and complete ADL's
- Establish baseline vital signs early in the stay
- Know their preferences
- Share what you know with your team

Performance Objectives

Participants will be able to:

- Summarize a resident's normal (baseline) condition for other team members
- Identify whether changes in a residents condition are significant or not
- Promote behaviors that improve change detection
- Use the SBAR tool
- Demonstrate good communication techniques
- Effectively communicate a change in a resident's condition

Key Lessons

- Learn to notice a change early
- Not reporting a change can lead to other things going wrong
- Taking action sooner is better

Recognizing Change

- Shift to shift comparison (how was the resident this morning, yesterday?)
- Differences in vital signs
- Differences in bowel and bladder status
- Because older people may have a serious illness and the only sign of that illness is some confusion, assessment of confusion is important
  - Brief Interview for Mental Status (BIMS), which evaluates the normal (baseline) mental function.
  - Modified Confusion Assessment Method (CAM), which is a simple set of questions that help to identify the presence of confusion.
  - PHQ-9 detects changes in mood, such as depression or anxiety.

Changes That Matter

Physical Changes
- Walking
- Urination and Bowel Patterns
- Skin
- Level of Weakness
- Falls
- Vital Signs

Non-Physical Changes
- Demeanor
- Appetite
- Sleeping
- Speech
- Confusion or Agitation
- Resident Complaints of Pain

Watching for Change

- The key is to always be watching
- Residents should be watched wherever they are, all the time
- Check in with residents often
- Talk with others who provide care for your residents
- **All members of the Interdisciplinary Team must watch for changes**

How to Follow Up on First Sign of Change

- Shift-to-shift comparisons
- Are there any changes that should be watched for or reported?
- SBAR tool:
  - SBAR stands for Situation, Background, Assessment, Recommendation
  - An effective tool for organizing data to assist with physician communication

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Observing and Reporting

- Who is responsible?
- Front-line providers are the eyes and ears of the team
- Part of helping the team perform best is sharing information
- Receptionists, occupational therapists, chaplains, volunteers, environmental service staff, nutrition service staff, other staff members, and visitors are important observers
- Any report you receive should be given sincere consideration as part of recognizing a change in condition

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Facilitating Condition Change Recognition

- **Consistent assignment**
  - Maintaining the same staff caring for the same residents allows those employees to more easily identify subtle changes
  - Staffing specialty units with those employees who are trained in specific disease/condition management
- **Take special care** with residents with dementia to get to know their baseline and watch them because changes for these residents can be sudden, and they may not be able to tell you what's wrong
- **Shift to shift comparison**
  - Promote effective shift change report
  - Encourage discussion amongst peers
- **Older people have less response to change**, so the signs and symptoms of illness they exhibit may be milder or different from those seen in younger people.

A Safe Environment

- Reporting changes helps keep resident's safe
- Learning and experience are what make safety possible
- Openly reporting anything that might affect a resident's well-being is essential for a safe environment
- Change in a resident's condition should be reported openly, whenever it happens.

A Safe Environment (cont.)

- Detecting and reporting change is essential to patient care
- Reporting changes is necessary for quality care
- Reporting involves the following skills:
  - Communicating what you have noticed to the care team and physician
  - Working together to identify what the change might mean
  - Working with the care team and physician to take action to make sure the resident is safe

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Communicating About Unwanted Events

- Learn to communicate promptly and openly when something happens that might affect a resident's well-being
- Move beyond blaming anyone to being able too openly share experiences
- Show you care by speaking up

Barriers to Communication

- Interpersonal issues
- Environmental or system barriers
- Workload issues
- Differences in:
  - Gender
  - Age/generation
  - Language
  - Culture
  - Status

We may face several communication barriers at the same time.

CONDITION SPECIFIC MONITORING

Communicating Changes in Condition

- Detecting and reporting changes in a resident's condition are the centerpiece of high quality care
- Move beyond blaming anyone to being able to openly share experiences.
- Show you care by speaking up and advocating for the resident
- Administration should create an environment where reporting is encouraged and promoted
- If in doubt, report!

Facilitating Condition Change Communication

- *Facility Specific Process/Tool for Communicating Change In Condition*
- *Facility Specific Process/Tool for communicating with the practitioner*
- Part of helping the team perform at it's best is sharing information.
- Current Areas of opportunity?
  – Everyone – residents and staff – benefits from an environment that supports discussion and learning from near misses and adverse events.

Dehydration

- Less urine output than usual; dark, concentrated urine
- Dry, cracked lips and mouth
- Fatigue
- Thirst (early stage)
- Absence of thirst (late stage)
- Poor skin turgor
- Dizziness or light headedness
- Constipation
- Increased respiratory and/or heart rate

Congestive Heart Failure (CHF)

- Sudden weight gain in 1 day or gradual weight gain over 3-7 days
- New or worsening swelling, or edema, of the lower extremities
- New or worsening shortness of breath
- Requires more supplemental oxygen than usual
- Coughing or wheezing
- Fatigue or feeling lightheaded
- Nausea or lack of appetite
- Confusion or impaired thinking
- Changes in lab values (e.g.; electrolytes, BNP)
- Elevated heart rate

Diabetes Complications

- Hyper/Hypoglycemia
- Impaired vision
- Fatigue
- Numbness, tingling in the feet and hands
- Nausea and vomiting
- Slow recovery from infections and wounds
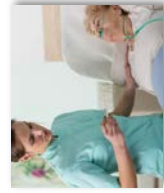- Yeast infections

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Heart Attack (Myocardial Infarction (MI))

- Chest pain and/or pressure
- Jaw, neck, back, or arm pain
- Diaphoresis (perfuse sweating)
- Lightheadedness, nausea, or vomiting
- Shortness of breath
- Anxiety

Infection

- Fever
- New or worsening confusion; delirium
- Foul odor and/or drainage from a wound or orifice
- Loss of appetite
- Increased respiratory and/or heart rate
- Increased pain, swelling, redness, or warmth around the affected area
- Weakness
- Decline in ADL function; falls

Cerebrovascular Accident (CVA)

- Slurred speech
- Facial drooping
- Weakness in one or more extremities
- Changes in ADL performance
- Numbness
- Difficulty walking or staying balanced
- Dizziness
- Severe headache without reason

Cancer Complications

- Pain
- Fatigue
- Difficulty breathing
- Nausea and/or vomiting
- Diarrhea or constipation
- Weight loss
- Brain and nervous system problems
- Infections

PROACTIVE
MEDICAL REVIEW

Additional Tools and Resources

- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapiresources.html

- https://www.ahcancal.org/advocacy/solutions/Pages/HospitalReadmissions.aspx

- https://www.ahrq.gov/professionals/systems/long-term-care/resources/facilities/ptsafety/ltcmodule1.html

PROACTIVE
MEDICAL REVIEW

Pneumonia

- Confusion or changes in mental status
- Chest discomfort with breathing and/or coughing
- Cough (with or without sputum production)
- Fatigue
- Fever
- Lower than normal body temperature
- Nausea, vomiting, or diarrhea
- Shortness of breath

PROACTIVE
MEDICAL REVIEW

Key Points Summary

- Detecting changes can prevent illness from getting worse
- Noticing changes in a resident's condition is important, but those changes must also be communicated to the physician
- Nursing staff know the resident best
- The need to share observations and respond to changes is very important
- Staff must know what's normal for the resident so it can be used for comparison when there is a change
- A safe environment is based on good communication

PROACTIVE
MEDICAL REVIEW

Chronic Obstructive Pulmonary Disease (COPD)

- New or worsening shortness of breath
- New or worsening cough (with or without sputum production) or wheezing
- New or worsening fatigue
- Decreased activity tolerance
- Requires more supplemental oxygen than usual
- Increased respirations and/or heart rate
- Difficulty sleeping and eating
- Increased use of PRN medications such as nebulizer treatments or anxiolytics

PROACTIVE
MEDICAL REVIEW

Renal Insufficiency (Kidney Disease)

- Nausea and vomiting
- Confusion
- Urinating only small amounts
- Swelling of the ankles
- Puffiness around the eyes
- Fatigue
- Shortness of breath
- Loss of appetite
- Increasingly higher blood pressure

PROACTIVE
MEDICAL REVIEW

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PROACTIVE
MEDICAL REVIEW

PROACTIVE
MEDICAL REVIEW

Identifying and Reporting Changes in Condition

Competencies for the Post Acute Provider

for non-licensed staff

Knowledge Objectives

Participants will be able to understand:

- Why detecting change is important
- How to know a residents normal (baseline) condition
- Assessing for change
- Effective use of the Early Warning tool
- How and what to communicate about change

Performance Objectives

Participants will be able to:

- Summarize a resident's normal (baseline) condition for other team members
- Identify whether changes in a residents condition are significant or not
- Promote behaviors that improve change detection
- Use the Early Warning tool
- Decide when to report or when to ask for help when observing changes in a resident's condition
- Effectively communicate a change in a resident's condition

Introduction

- Most older adults have at least two or more chronic conditions, including diabetes, heart disease/stroke, and cancer. These conditions can lower quality of life, lead to a wide array of complications, and even shorten lifespans. Three of the most common chronic diseases seen in skilled nursing centers are diabetes, heart disease/stroke, and cancer.(1)
- Common causes for hospital admissions for older adults include CHF, COPD, DM, infection, pneumonia, and stroke.(2)
- Early detection and communication of changes in condition is imperative to assuring resident safety and attaining or maintaining the highest practicable physical, mental, and psychosocial well-being of each resident.

Case Study

Ms. Smith, a 79-year-old woman, was admitted to SNF after a hip fracture. She walks with difficulty with a walker and needs help with ADLs. Ms. Smith also has several other medical problems including high blood pressure, diabetes, and arthritis, and is also being treated for depression. Her family visits regularly on weekends. She rarely participates in activities; at mealtimes she avoids conversation. Recently she had diarrhea, was incontinent of liquid stool, and nursing assistants had to change her adult briefs once or twice per shift. She began taking meals in her room. Stool tests showed that she had a bowel infection with Clostridium difficile. An antibiotic was started. Even with the antibiotic, her bowel movements continued to be liquid and frequent over the next week, and she was eating less. Her blood pressure had been normal for her, but her pulse rate was 90-100 yesterday, which was higher than her usual 70-75. Yesterday, she had a fever of 102.5 and was transferred to the acute hospital, where she was admitted to the Intensive Care Unit.

- How did Ms. Smith get so sick with only diarrhea?
- What symptoms might have been noticed sooner?
- When might you have decided to report it?
- What would you have reported and to whom?
- How do you know when the communication has worked?

Key Lessons

- Learn to notice a change early
- Not reporting a change can lead to other things going wrong
- Taking action sooner is better

Nursing Assistants

- Nursing Assistants are the providers who see the resident most often
- They are the eyes, ears, and hands of the care team
- Detecting change is one of their most important responsibilities
- Nursing Assistants should ask themselves: What just happened and what was it like before that is now different?
- Subtle changes are important and may be indicative of a larger problem
- Assuming that someone knows what is happening just because they have a higher position is often incorrect.

Knowing the Resident's Baseline Condition

- Take time to get to know your residents
- Talk with team members, the resident, and their family/representative
- Actively participate in change of shift report
- Take note of the resident's ability to move around and complete ADLs
- Know their preferences
- Share what you know with your team

Recognizing Change

- Shift to shift comparison (how was the resident this morning, yesterday?)
- Differences in vital signs
- Differences in bowel and bladder status
- New or unusual behavior(s)
- The resident "just doesn't seem like" him or herself – ask questions, dig deeper, look closer!

PROACTIVE
MEDICAL REVIEW

Changes That Matter

Physical Changes
- Walking
- Urination and Bowel Patterns
- Skin
- Level of Weakness
- Falls
- Vital Signs

Non-Physical Changes
- Demeanor
- Appetite
- Sleeping
- Speech
- Confusion or Agitation
- Resident Complaints of Pain

Physical Changes

Walking – e.g., the resident needs more assistance with walking; shuffling steps; loss of balance

Urination and bowel patterns – e.g., the resident is urinating less frequently; new onset or worsening incontinence; constipation; diarrhea

Skin – e.g., the resident's skin is puffy; new or worsening wound; local or body wide rash; dry, cracked lips

Level of weakness – e.g., the resident is having difficulty lifting his or her arm; generalized weakness; new or worsening fatigue

Falls risk – e.g., the resident reaches for objects when in a wheelchair; new or recently changed medications; potential sign of underlying illness

Vital signs – e.g., the resident is breathing faster than normal; elevated blood pressure; decreased oxygen saturation

Non-Physical Changes

Demeanor – e.g., the resident is socializing less than normal; inattentive; withdrawn

Appetite – e.g., the resident is not interested in his or her food; skipping meals; nausea

Sleeping – e.g., the resident falls asleep in unusual places; difficult to rouse from sleep; insomnia

Speech – e.g., the resident's speech is slurred; trouble chewing and/or swallowing food

Confusion or agitation – e.g., the resident is talking a lot more or less than usual; resistance to care

Resident complaints of pain – e.g., the resident grimaces or winces when he or she moves; verbal complaints of discomfort

Watching for Change

- The key is to always be watching for possible changes
- Residents should be watched wherever they are, all the time
- Check in with residents often
- Talk with others who provide care for your residents
- **All members of the Interdisciplinary Team must watch for changes**

What is important enough to report?

- Not every "change" has to be significant. In general, for every three to five reports, only one full assessment is done.
- It is most important to report anything that might matter

How to Follow Up at First Sign of Change

- Shift-to-shift comparisons (is it a change?)
- Are there any changes that should be watched for or reported?
- Early Warning tool:
  - Use the tool anytime a resident has had a change
  - Complete the tool and give it to the nurse along with a verbal report

A Safe Environment

- Reporting changes helps keep resident's safe
- Learning and experience are what make safety possible
- Openly reporting anything that might affect a resident's well-being is essential for a safe environment
- Change in a resident's condition should be reported openly, whenever it happens.

A Safe Environment (cont.)

- Detecting and reporting change is essential to patient care
- Reporting changes is necessary for quality care
- Reporting involves the following skills:
  - Communicating what you have noticed to the care team
  - Working together to identify what the change might mean
  - Working with the care team to take action to make sure the resident is safe

Communicating About Unwanted Events

- Learn to communicate promptly and openly when something happens that might affect a resident's well-being
- Move beyond blaming anyone to being able to openly share experiences
- Show you care by speaking up

PROACTIVE
MEDICAL REVIEW

CONDITION SPECIFIC MONITORING

Barriers to Communication

- Interpersonal issues
- Environmental or system barriers
- Workload issues
- Differences in:
  - Gender
  - Age/generation
  - Language
  - Culture
  - Status

We may face several communication barriers at the same time.

Communicating Changes in Condition

- Detecting and reporting changes in a resident's condition are the centerpiece of high quality care
- Move beyond blaming anyone to being able to openly share experiences.
- Show you care by speaking up and advocating for the resident
- Administration should create an environment where reporting is encouraged and promoted
- If in doubt, report!

Dehydration

- Less urine output than usual; dark, concentrated urine
- Dry, cracked lips and mouth
- Fatigue
- Thirst (early stage)
- Absence of thirst (late stage)
- Poor skin turgor
- Dizziness or light headedness
- Constipation
- Increased respiratory and/or heart rate

Congestive Heart Failure (CHF)

- Sudden weight gain in 1 day or gradual weight gain over 3-7 days
- New or worsening swelling, or edema, of the lower extremities
- New or worsening shortness of breath
- Requires more supplemental oxygen than usual
- Coughing or wheezing
- Fatigue or feeling lightheaded
- Nausea or lack of appetite
- Confusion or impaired thinking
- Elevated heart rate

Diabetes Complications

- Hyper/Hypoglycemia
- Impaired vision
- Fatigue
- Numbness, tingling in the feet and hands
- Nausea and vomiting
- Slow recovery from infections and wounds
- Yeast infections

Heart Attack (Myocardial Infarction (MI))

- Chest pain and/or pressure
- Jaw, neck, back, or arm pain
- Diaphoresis (perfuse sweating)
- Lightheadedness, nausea, or vomiting
- Shortness of breath
- Anxiety

Infection

- Fever
- New or worsening confusion; delirium
- Foul odor and/or drainage from a wound or orifice
- Loss of appetite
- Increased respiratory and/or heart rate
- Increased pain, swelling, redness, or warmth around the affected area
- Weakness
- Decline in ADL function; falls

Cerebrovascular Accident (CVA)

- Slurred speech
- Facial drooping
- Weakness in one or more extremities
- Changes in ADL performance
- Numbness
- Difficulty walking or staying balanced
- Dizziness
- Severe headache without reason

Cancer Complications

- Pain
- Fatigue
- Difficulty breathing
- Nausea and/or vomiting
- Diarrhea or constipation
- Weight loss
- Brain and nervous system problems
- Infections

Pneumonia

- Confusion or changes in mental status
- Chest discomfort with breathing and/or coughing
- Cough (with or without sputum production)
- Fatigue
- Fever
- Lower than normal body temperature
- Nausea, vomiting, or diarrhea
- Shortness of breath

Chronic Obstructive Pulmonary Disease (COPD)

- New or worsening shortness of breath
- New or worsening cough (with or without sputum production) or wheezing
- New or worsening fatigue
- Decreased activity tolerance
- Requires more supplemental oxygen than usual
- Increased respirations and/or heart rate
- Difficulty sleeping and eating

Renal Insufficiency (Kidney Disease)

- Nausea and vomiting
- Confusion
- Urinating only small amounts
- Swelling of the ankles
- Puffiness around the eyes
- Fatigue
- Shortness of breath
- Loss of appetite
- Increasingly higher blood pressure

Key Points Summary

- Detecting changes can prevent illness from getting worse
- Noticing changes in a resident's condition is important, but those changes must also be communicated
- Nursing Assistants often know the resident best
- The need to share observations and respond to changes is very important
- Staff must know what's normal for the resident so it can be used for comparison when there is a change
- A safe environment is based on good communication

Tools and Resources

- *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapiresources.html*

- *https://www.ahcancal.org/advocacy/solutions/Pages/HospitalReadmissions.aspx*

- *https://www.ahrq.gov/professionals/systems/long-term-care/resources/facilities/ptsafety/ltcmodule1.html*

Instructor Led Simulation

Case Study #1

Ms. Jones is a 74-year-old woman who admitted to the SNF three days ago following cardiac surgery (CABGx3).

This is your first time caring for her, and from report you know that she is weak, requires extensive assistance of 1 with transfers and ADL's, and has been nauseated since her admission related to her pain medication. Upon entering her room, you see that she is vomiting. She states her AM medications have made her sick and voices no other complaints.

You attempt to help her from the bed to her chair to assist her with hygiene, but she is too weak for you to transfer safely on your own.

Prompt the participant(s) to do the following, if not self-initiated:

Shift to shift comparison:
- Record review reveals no documentation of previous emesis.
- Record review reveals that she has consistently required only 1 assist with transfers

Peer interview:
- Sally, NA reports that Ms. Jones vomited once during AM care, but it was a small amount and she thought it was due to her medications.
- Laura, RN reports that Ms. Jones received her pain medication over 2 hours ago.

After data collection, the NA should report the change to the nurse verbally and by using an early warning tool.

The LN should then complete an assessment on Ms. Jones focusing on cardiac function.

Assessment:
- Ms. Jones' BP is elevated at 182/94
- Ms. Jones' pulse is elevated at 100
- Apical pulse reveals an irregularity
- If asked, Ms. Jones also admits to chest discomfort and jaw pain

The LN should then organize data using your facility's tool for communicating with the practitioner and notify the physician and emergency services by phone related to suspected MI.

Instructor Led Simulation

Case Study #2

Mr. Green is an 86-year-old man who is a long-term resident of the SNF. He has advanced dementia and is receiving hospice services. He requires extensive to total assistance of 2 with transfers and ADLs. He is non-verbal.

You know Mr. Green well, but have been off on vacation for the last 5 days. As you are providing AM care, you notice that Mr. Green seems restless and uncomfortable which is unusual for him. He moans when you reposition him, and you think his abdomen seems larger and rounder then when you saw him last.

Prompt the participant(s) to do the following, if not self-initiated:

Shift to shift comparison:
- Record review reveals no documentation of a bowel movement for 5 days.
- Record review reveals meal and fluid consumption percentage has been lower than average.

Peer interview:
- Sally, NA reports that Mr. Green has not eaten as well as usual for the past 2 days.
- Laura, RN reports that Mr. Green's pain medication was increased by hospice services a few days ago.

After data collection, the NA should report the change to the nurse verbally and by using an early warning tool.

The LN should then complete an assessment on Mr. Green focusing on GI function.

Assessment:
- Mr. Green's abdomen is firm and distended
- Mr. Green's bowel sounds are absent
- Mr. Green moans when his abdomen is palpated

The LN should then organize data using your facility's tool for communicating with the practitioner and notify the physician by phone related to suspected bowel obstruction.

Instructor Led Simulation

Case Study #3

Mrs. Smith is a 68-year-old woman who admitted to the SNF 7 days ago following an elective Right hip replacement. She is alert and oriented x4 and only requires limited assistance with ADLs. The unit she is on currently has several patients ill with a stomach virus causing vomiting and diarrhea. Mrs. Smith begins vomiting this morning during therapy. The LN notifies the physician and obtains an order for IM Phenergan to treat the nausea and vomiting most likely caused by the virus.

Throughout your shift you notice that Mrs. Smith continues with nausea and vomiting despite the Phenergan and is also becoming weaker and confused. You are concerned that something is, "just not right".

Prompt the participant(s) to do the following, if not self-initiated:

Shift to shift comparison:
- Record review reveals that Mrs. Smith has consistently required limited assist of 1 with ADLs.
- Record review reveals meal and fluid consumption percentage has been adequate.

Peer interview:
- Sally, NA reports that Mrs. Smith had a fall 2 days ago and has been a bit weaker since.
- Laura, RN reports that Mrs. Smith hit her head during the fall, but neuro-checks have been within normal limits.

After data collection, the NA should report the change to the nurse verbally and by using an early warning tool.

The LN should then complete an assessment on Mrs. Smith.

Assessment:
- Mrs. Smith is afebrile.
- Mrs. Smith is alert but disoriented.
- Mrs. Smith's Right pupil is non-reactive to light.
- Mrs. Smith complains of a gradually worsening headache.

The LN should then organize data using your facility's tool for communicating with the practitioner and notify the physician by phone related to suspected head injury.

Case Study #1

Ms. Jones is a 74-year-old woman who admitted to the SNF three days ago following cardiac surgery (CABGx3).

This is your first time caring for her, and from report you know that she is weak, requires extensive assistance of 1 with transfers and ADL's, and has been nauseated since her admission related to her pain medication. Upon entering her room, you see that she is vomiting. She states her AM medications have made her sick and voices no other complaints.

You attempt to help her from the bed to her chair to assist her with hygiene, but she is too weak for you to transfer safely on your own.

Case Study #2

Mr. Green is an 86-year-old man who is a long-term resident of the SNF. He has advanced dementia and is receiving hospice services. He requires extensive to total assistance of 2 with transfers and ADLs. He is non-verbal.

You know Mr. Green well, but have been off on vacation for the last 5 days. As you are providing AM care, you notice that Mr. Green seems restless and uncomfortable which is unusual for him. He moans when you reposition him, and you think his abdomen seems larger and rounder then when you saw him last.

Case Study #3

Mrs. Smith is a 68-year-old woman who admitted to the SNF 7 days ago following an elective Right hip replacement. She is alert and oriented x4 and only requires limited assistance with ADLs. The unit she is on currently has several patients ill with a stomach virus causing vomiting and diarrhea. Mrs. Smith begins vomiting this morning during therapy. The LN notifies the physician and obtains an order for IM Phenergan to treat the nausea and vomiting most likely caused by the virus.

Throughout your shift you notice that Mrs. Smith continues with nausea and vomiting despite the Phenergan and is also becoming weaker and confused. You are concerned that something is, "just not right".

Handout for Case Study participants

Case studies are meant to simulate a scenario that you are likely to encounter during your work day. Treat this case study as a real-life occurrence and think about how you would react, what you would do, and most importantly, how you can help your resident.

After reading the Case Study, or participating in the simulation, think about the following:

1. **What is happening with the resident now, and how is this different from before?**

2. **If I've just met this resident, how can I find out more information about them and determine if this is a change?**

3. **If this is a change, who do I report to and how?**

4. **After I've reported, what else should I do for the resident?**

5. **How do I know my communication was effective?**

PROACTIVE
MEDICAL REVIEW

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This tool is designed to examine each hospital transfer and assist with identifying gaps in competence regarding identification and reporting of changes in condition. Complete this tool for each hospital transfer and review for process changes and/or educational opportunities.

Resident Name: _____

Date of most recent admission to the facility: ____ / ____ / ____

Date of discharge to the hospital: ____ / ____ / ____

Staff on duty at time of transfer: _____
_____

Contributing factors to hospitalization:

☐ Cancer   ☐ Fracture

☐ CHF   ☐ Multiple co-morbidities

☐ COPD   ☐ Polypharmacy (e.g. 9 or more medications)

☐ Dementia   ☐ Surgical complications

☐ Diabetes   ☐ Other (describe) _____

☐ End-stage renal disease

Date the change in condition was first identified: ____ / ____ / ____

Briefly describe the change(s) in condition: _____
_____
_____

Briefly describe how the changes were evaluated and interventions that were implemented prior to the transfer:
_____
_____
_____

Clinician authorizing transfer: _____   Hospital admitting diagnosis: _____

In retrospect, could the transfer potentially have been prevented? ☐ No   ☐ Yes (explain)
_____
_____
_____

Was change in condition appropriately identified, reported, and managed?
☐ Yes   ☐ No (describe process changes and/or additional education needs identified)
_____
_____
_____

PROACTIVE
MEDICAL REVIEW

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Changes That Matter

Appetite – e.g., not interested in food; skipping meals; nausea

Confusion or agitation – e.g., talking a lot more or less than usual; resistance to care

Demeanor – e.g., socializing less than normal; inattentive; withdrawn

Falls risk – e.g., reaching for objects when in a wheelchair; new or recently changed medications; potential sign of underlying illness

Level of weakness – e.g., difficulty lifting arm or leg; generalized weakness; new or worsening fatigue

Resident complaints of pain – e.g., grimaces or winces when moved; verbal complaints of discomfort

Skin – e.g., skin is puffy; new or worsening wound; local or body wide rash; dry, cracked lips

Sleeping – e.g., falls asleep in unusual places; difficult to rouse from sleep; insomnia

Speech – e.g., speech is slurred; trouble chewing and/or swallowing food

Urination and bowel patterns – e.g., urinating less frequently; new onset or worsening incontinence; constipation; diarrhea

Vital signs – e.g., breathing faster than normal; elevated blood pressure; decreased oxygen saturation

Walking – e.g., needs more assistance with walking; shuffling gait; loss of balance

Learn to notice a change early

☐ Detecting change is one of your most important responsibilities

☐ Ask yourself: What just happened and how is it different than normal?

☐ Know your resident's baseline

☐ Actively participate in change of shift report

☐ Share what you know with your team

☐ Residents should be monitored wherever they are, all the time

Not reporting a change can lead to other things going wrong

☐ Reporting changes helps keep resident's safe

☐ Subtle changes can be indicative of larger problems

☐ Change in a resident's condition should be reported openly, whenever it happens

Acting sooner is better

☐ Are there any changes that should be watched for or reported?

☐ Utilize the Early Warning tool to give and receive information

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PROACTIVE
MEDICAL REVIEW

Identifying & Reporting Changes in Condition

Instructions:

Complete this form in adjunct with a simulation and/or case study review.
Indicate the level of staff competency in identifying changes in condition by checking the appropriate response:

S= Satisfactory, I= Intermediate, U=Unsatisfactory

#	Competency Item	S	I	U
1.	(NA) Demonstrates ability to identify changes from the resident's baseline condition	☐	☐	☐
	☐ Gathering data	☐	☐	☐
	☐ Shift-to-shift comparison	☐	☐	☐
	☐ Discussion with resident and/or co-workers	☐	☐	☐
2.	(NA) Effectively communicates condition change to the LN	☐	☐	☐
3.	(LN) Demonstrates ability to apply critical thinking and clinical judgement during the assessment of the resident	☐	☐	☐
4.	(LN) Effectively assesses the resident	☐	☐	☐
	☐ Current status	☐	☐	☐
	☐ Vital signs	☐	☐	☐
	☐ History	☐	☐	☐
	☐ Allergies	☐	☐	☐
	☐ Chief complaint	☐	☐	☐
	☐ Medications	☐	☐	☐
	☐ Labs/diagnostics	☐	☐	☐
	☐ Mental status	☐	☐	☐
	☐ Other information as applicable	☐	☐	☐
5.	(LN) Demonstrates ability to organize assessment information and effectively communicate the condition change to the practitioner using SBAR or SOAP format	☐	☐	☐

Comments:

Staff Name: _____ ☐ NA ☐ LN   Date: _____ / _____ / _____

Competency Monitor: _____

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PROACTIVE
MEDICAL REVIEW

Pre/Post-Test

Name: _____   Title: _____

Date: ____ / ____ / ____   Check one: □ Pre-Test   □ Post-Test

1. **What environmental factors positively contribute to identifying changes in a resident's condition?**
   a. One where providers know the residents and their routines.
   b. One where staff are punished for reporting safety concerns.
   c. One where people only feel comfortable to report anonymously.
   d. One in which only supervisors/leadership may address concerns about residents.

2. **Mr. L has been in the facility for a month. He has a pressure ulcer that developed weeks ago and measurements are about the same as last week. The nurse should:**
   a. Make no mention of it at report.
   b. Mention it at report, noting that it is unchanged, and when the nurse/doctor will next review the situation.
   c. Tell Mr. L to 'eat more and fatten up a bit!'
   d. Talk critically about the resident's care privately to coworkers.

3. **Which of the following are part of gauging a resident's normal patterns?**
   a. Talking with the resident about things that are important to the resident.
   b. Assessment of consciousness and function.
   c. Reviewing the resident's health record.
   d. All of the above.

4. **You notice that a resident not assigned to you is angrily demanding his lunch. You are surprised because he is usually quiet and patient. Which of the following is the best next step?**
   a. You ask the licensed nurse if she has noticed any change in his mood or behavior, and how he is feeling today.
   b. You go get his lunch because the other assistant is running behind.
   c. You ask the resident what is wrong, telling him you will check on his lunch, and then notify the licensed nurse responsible for the resident about the possible change in condition.
   d. You do nothing, as this is the first time it has occurred.

5. **If a sudden change in a resident's condition is noticed, what should the nursing assistant do?**
   a. Notify a supervisor.
   b. Document the change in the resident's record.
   c. Check with a co-worker about any previous history of similar events.
   d. All of the above.

6. **The best way to communicate information about your resident to other members of the care team is:**
   a. Talking directly to the staff on the next shift.
   b. Writing it on a loose piece of paper at the nurses' station.
   c. Telling the resident to tell the doctor on the next visit.
   d. All of the above.

Test continued on next page...

Pre/Post-Test *Continued...*

7.   **Steps in good communication include:**
   a. Set the stage, find out what the coworker understands, give the information, understand the coworkers' perspective, and end the communication with a plan for next steps.
   b. Making sure a supervisor communicates with the coworker.
   c. Ensuring that the coworker knows it is his or her responsibility to understand relevant matters.

8.   **Which of the following should you communicate to the licensed nurse on duty in addition to the next shift nursing assistant?**
   a. Your resident drank only one glass of fluid all day today.
   b. For the first time, your resident was not able to support her/his weight while transferring to a chair.
   c. Your normally cooperative resident cursed at you this morning.
   d. All of the above

9.   **Mr. Hanes suffers from COPD and routinely has a cough. He slept in his recliner last night and is now requesting an additional nebulizer treatment. You should report this to the licensed nurse as a change in condition.**
   a. True
   b. False

10.   **When assessing a resident with CHF for a potential change in condition, you should evaluate:**
   a. Weight gain or loss
   b. Lower extremity edema (swelling)
   c. If they are short of breath
   d. All of the above

Pre/Post-Test Questions with Answers

1. **What environmental factors positively contribute to identifying changes in a resident's condition?**
   a. One where providers know the residents and their routines.
   b. One where staff are punished for reporting safety concerns.
   c. One where people only feel comfortable to report anonymously.
   d. One in which only supervisors/leadership may address concerns about residents.

2. **Mr. L has been in the facility for a month. He has a pressure ulcer that developed weeks ago and measurements are about the same as last week. The nurse should:**
   a. Make no mention of it at report.
   b. Mention it at report, noting that it is unchanged, and when the nurse/doctor will next review the situation.
   c. Tell Mr. L to 'eat more and fatten up a bit!'
   d. Talk critically about the resident's care privately to coworkers.

3. **Which of the following are part of gauging a resident's normal patterns?**
   a. Talking with the resident about things that are important to the resident.
   b. Assessment of consciousness and function.
   c. Reviewing the resident's health record.
   d. All of the above.

4. **You notice that a resident not assigned to you is angrily demanding his lunch. You are surprised because he is usually quiet and patient. Which of the following is the best next step?**
   a. You ask the licensed nurse if she has noticed any change in his mood or behavior, and how he is feeling today.
   b. You go get his lunch because the other assistant is running behind.
   c. You ask the resident what is wrong, telling him you will check on his lunch, and then notify the licensed nurse responsible for the resident about the possible change in condition.
   d. You do nothing, as this is the first time it has occurred.

5. **If a sudden change in a resident's condition is noticed, what should the nursing assistant do?**
   a. Notify a supervisor.
   b. Document the change in the resident's record.
   c. Check with a co-worker about any previous history of similar events.
   d. All of the above.

6. **The best way to communicate information about your resident to other members of the care team is:**
   a. Talking directly to the staff on the next shift.
   b. Writing it on a loose piece of paper at the nurses' station.
   c. Telling the resident to tell the doctor on the next visit.
   d. All of the above.

Test continued on next page...

Pre/Post-Test Questions with Answers *Continued...*

7.   **Steps in good communication include:**
     a.   Set the stage, find out what the coworker understands, give the information, understand the coworkers' perspective, and end the communication with a plan for next steps.
     b.   Making sure a supervisor communicates with the coworker.
     c.   Ensuring that the coworker knows it is his or her responsibility to understand relevant matters.

8.   **Which of the following should you communicate to the licensed nurse on duty in addition to the next shift nursing assistant?**
     a.   Your resident drank only one glass of fluid all day today.
     b.   For the first time, your resident was not able to support her/his weight while transferring to a chair.
     c.   Your normally cooperative resident cursed at you this morning.
     d.   All of the above

9.   **Mr. Hanes suffers from COPD and routinely has a cough. He slept in his recliner last night and is now requesting an additional nebulizer treatment. You should report this to the licensed nurse as a change in condition.**
     a.   True
     b.   False

10. **When assessing a resident with CHF for a potential change in condition, you should evaluate:**
     a.   Weight gain or loss
     b.   Lower extremity edema (swelling)
     c.   If they are short of breath
     d.   All of the above

PROACTIVE
MEDICAL REVIEW

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Appendix E

PROACTIVE

MEDICAL REVIEW

Competency Based Training & Assessment
Made Easy!

Competency Assessment Sample Policy

This Sample Policy is intended to serve as a guide to updating existing staff development/ training policies and procedures.

Competency Assessment Sample Policy

I. Policy Statement and Purpose

The purpose of this policy is to describe the minimum requirements for ensuring the appropriate competencies and skill sets of employees to perform their work-related duties, including providing services to meet the resident's needs safely and in a manner that promotes each resident's rights, physical, mental and psychosocial well-being. Documentation of ongoing competency assessment will be maintained as defined based on the job description and corresponding competency requirements.

II. Procedures

Competency of employees to demonstrate appropriate skills in performing their essential job functions will be assessed during the orientation process and at least annually thereafter, unless otherwise stated based on department specific policy.

1. Competency is defined as: a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully.

2. The facility assessment will address the staff competencies that are necessary to provide the levels and types of care needed for the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within the resident population.

3. The facility will determine the amount and types of training required based on the facility assessment.

4. All staff are expected to demonstrate competency with the activities listed in the training requirements per §483.95, such as preventing and reporting abuse, neglect, and exploitation, dementia management, and infection control.

5. Nurse aides are expected to demonstrate competency with the activities and components that are required to be part of an approved nurse aide training and competency evaluation program, per §483.152.

6. Competency assessments will evaluate skills and techniques necessary to care for residents' needs including, but not limited to competencies in areas such as:
   a. Respecting Resident Rights, including promoting resident independence;
   b. Person centered care;
   c. Communication and interpersonal skills;
   d. Basic nursing skills;
   e. Basic restorative services;
   f. Skin and wound care;
   g. Medication management;
   h. Pain management;
   i. Infection control;
   j. Identification of changes in condition;
   k. Cultural competency;
   l. Implementing non-pharmacological interventions;
   m. Caring for the resident's environment;
   n. Mental health and social service needs; and
   o. Care of cognitively impaired residents

7. Staff's ability to use and integrate the knowledge and skills that are the subject of facility trainings will be assessed and evaluated by staff already determined to be competent in those skill areas.

8. Examples of methods used to evaluate staff competencies include but are not limited to:
   a. Lecture with return demonstration for physical activities;
   b. A pre-and post-test for documentation issues;

    c. Demonstrated ability to use tools, devices, or equipment that were the subject of training and used to care for residents;

    d. Reviewing adverse events that occurred as an indication of gaps in competency; and/or

    e. Demonstrated ability to perform activities that is in the scope of practice an individual is licensed or certified to perform.

9. Nursing leadership, with input from the Medical Director, will delineate the competencies required for all nursing staff to deliver, individualize, and provide safe care for the facility's residents.

10. Staff selection will follow personnel policies and include verification of education, training, experience, and verification of licensure/certification as relevant depending on the requirements of the position.

11. All new employees will receive a complete orientation, to include general facility education requirements, as well as position specific training.

    a. All new employees must satisfactorily demonstrate competency in assigned skills prior to being assigned to work independently. Competency verification may include, but is not limited to:

        i. Demonstration of an understanding of the core job functions and essential duties for their position;

        ii. Job specific skills assessment and competency verification completed within a designated time frame from start of work;

        iii. Supported learning via teaching methods such as job shadowing and assigned mentoring; and/or

        iv. Ongoing evaluation and feedback from supervisory/mentoring staff with identification of training and support needs, and implementation of skills improvement action plans as needed.

12. Ongoing competency will be assessed at least annually and/or as indicated during orientation, based on individual performance appraisals, when new procedures are introduced, or as job duties change. The primary supervisor in partnership with the staff development coordinator will be responsible for evaluating staff skill levels, and developing individualized competency-based training, that ensures resident safety and quality of care and service being delivered. Methods for competency verification may include:

    a. Annual performance appraisal assessing components of required duties and responsibilities of the job description;

    b. Annual competency assessments using formats such as checklists of key job skills including self-evaluation, skills fairs, training topics, return demonstrations, supervisor observation/evaluation, case study review with knowledge application discussion, and completion of job related topic specific posttests;

    c. Interim competency assessments to assess competence as new procedures or techniques are introduced, when job duties change and as indicated by individual performance;

    d. Verification and copies of current licensure and certifications as required, and assurance of completion of required or recommended trainings as appropriate for the assigned responsibilities;

    e. Chart review and record audits as applicable to the position; and/or

    f. Identification of gaps in education that is contributing to poor outcomes (e.g. potentially preventable re-hospitalization) with educational programing to address these gaps.

13. Competency assessment with observation and training may be utilized at any time during employment when:

    a. Requested by the employee or based on an employee's feedback that they are needing improvement or lacking in knowledge and skill for the assigned job.

    b. When issues or trends are identified demonstrating an inability to perform the assigned job satisfactorily.

        i. Unsatisfactory job performance and/or competency will be addressed by the supervisor at the time of occurrence.

        ii. A written improvement plan may be required when competency and/or substandard performance issues are identified.

14. The Company will promote ongoing competency of employees by providing access to educational opportunities that foster continued growth and quality performance for the position.

Competency Assessment Policy *Continued..*

Source Documents & References	
Federal Regulations	*F726 §483.35; F741 §483.40(a); F801 §483.60(a); F826 §483.65(b), F839, §483.70(f)*
OBRA Regulations	
Related Documents	

Approvals	Printed Name	Signature	Date
Executive Leadership			
Chief Compliance Officer			
REVIEW and REVISIONS			
Version #: Date:			
Summary of changes:			
Version #: Date			
Summary of Changes:			

PROACTIVE
MEDICAL REVIEW

Appendix F

Participant Evaluation/
Satisfaction Questionnaire

1. Learning objectives were met
   a) Excellent
   b) Good
   c) Average
   d) Needs Improvement
   e) Unsatisfactory

2. Appropriateness of topic and content to long term care
   a) Excellent
   b) Good
   c) Average
   d) Needs Improvement
   e) Unsatisfactory

3. Usefulness of the knowledge/ skills acquired
   a) Excellent
   b) Good
   c) Average
   d) Needs Improvement
   e) Unsatisfactory

4. Value of the tools, resources and materials provided in implementing an improved competency assessment/training program
   a) Excellent
   b) Good
   c) Average
   d) Needs Improvement
   e) Unsatisfactory

Appendix G

Budget Item	2020 Hours	FY2020 12/1/19-6/30/20	2021 Hours	FY2021 7/1/20-6/30/21	2022 Hours	FY2022 7/1/21-6/30/22	Project Total
Training content development @ $185/hour	240	$ 44,400.00	40	$ 7,400.00			$ 51,800.00
12 compentency tool kits & facility resources	184	$ 34,040.00					$ 34,040.00
Test development: certification testing, webinar modules, course descriptions for CE approvals, satisfaction survey development	8	$ 1,480.00	13	$ 2,405.00			$ 3,885.00
Ohio Nursing CE approval fees		$ 1,325.00					$ 1,325.00
Room Rental for 4 Venue Cities (3 Training Days)		$ 4,000.00		$ 2,000.00			$ 6,000.00
Mileage for Training		$ 1,850.47		$ 1,850.48			$ 3,700.95
Overnight Rooms Training (trainers & coordinator)		$ 2,880.00		$ 1,440.00			$ 4,320.00
GoTo Webinar Hosting x 18 months @ $199/mo				$ 2,388.00		$ 2388.00	$ 4776.00
Handout Material		$ 293.34		$ 146.66			$ 440.00
12 Editable Competency Toolkits		$ 47,040.00					$ 47,040.00
Basic Nursing Skills Editable Workbook		$ 7,920.00					$ 7,920.00
SNF/NF Staff Dept. Specific Workbook		$ 5,520.00					$ 5,520.00
Competency Policy Procedure Template		$ 2,320.00					$ 2,320.00
Project Coordinator Labor @ $25/hr	420	$ 10,500.00	440	$ 11,000.00	120	$ 3,000.00	$ 24,500.00
Trainer Labor (In person Training/ Testing) x 2 Trainers x 4 venues	96	$ 17,760.00	48	$ 8,880.00			$ 26,640.00
Trainer Labor (12 webinars)	12	$ 2,220.00					$ 2,220.00
Support Activities -Labor			61	$ 11,285.00			$ 11,285.00
Sustainability Activities-Labor			58	$ 10,730.00	50	$ 9,250.00	$ 19,980.00
Reporting Activities	10	$ 1,850.00	20	$ 3,700.00	26	$ 4,810.00	$ 10,360.00
TOTALS		$ 185,398.81		$ 63,225.14		$ 19,448.00	$ 268,071.95

Appendix H

KAHCF EDUCATION
SPEAKER EVALUATION SUMMARY

OFFERING/TITLE: Care Coach Fundamentals – Improving Staff Competency Programs

PRESENTER: Shelly Maffia

DATE: August 30, 2018

1. The speaker(s) was/were well prepared, articulate and interesting.

5-Strongly Agree	4-Agree	3-Disagree	2-Strongly Disagree	1-N/A
22	5	0	0	0

2. I would attend another seminar by the speaker(s).

5-Strongly Agree	4-Agree	3-Disagree	2-Strongly Disagree	1-N/A
19	9	0	0	0

3. The course met my expectations.

5-Strongly Agree	4-Agree	3-Disagree	2-Strongly Disagree	1-N/A
16	12	0	0	0

4. The course increased my knowledge as a provider and was pertinent to my needs.

5-Strongly Agree	4-Agree	3-Disagree	2-Strongly Disagree	1-N/A
20	8	0	0	0

5. The course flowed smoothly and followed a logical sequence.

5-Strongly Agree	4-Agree	3-Disagree	2-Strongly Disagree	1-N/A
21	6	1	0	0

6. The subject matter was well covered.

5-Strongly Agree	4-Agree	3-Disagree	2-Strongly Disagree	1-N/A
21	7	0	0	0

7. Enough time was allotted for discussion.

5-Strongly Agree	4-Agree	3-Disagree	2-Strongly Disagree	1-N/A
19	8	1	0	0

8. The handouts were well prepared and enhanced the program.

5-Strongly Agree	4-Agree	3-Disagree	2-Strongly Disagree	1-N/A
20	8	0	0	0

9. Additional Comments

This was a very useful and relevant meeting

I would give her a 10 if I could! She is excellent! Absolutely love her training style!

Very used to speaker through monthly webinar

This was very informative and helpful. Shelly did a great job presenting information. ☺

Well thought out and applicable

Very useful and informative for me in my position as Quality Assurance Director

Started a little timidly but improved after about 20 minutes

Need more powerpoints on each subject could be helpful

Appendix I

Q1 Please describe your experience using the Competency Tool-kit items purchased through Proactive in assisting your facility to implement/improve competency based staff training in your facility (e.g. time saved in developing tools in-house, clinical quality, ease of use, level to which tools impacted competency related survey outcomes, etc.)

Answered: 6   Skipped: 0

#	RESPONSES	DATE
1	I can't say enough about these toolkits. Our facility purchased several(8) of the toolkits to help improve our staff training by having a tool that was already developed and was easy to edit and modify to add additional information we needed, without all the time involved recreating something. The clinical quality of the toolkits were good, and so ease to use and understand. I believe the toolkits will help us with our survey that is coming any time now by having competency for staff documented and available to review if necessary.	8/7/2019 12:50 PM
2	I really like the tool kits. Easy to use and offered great knowledge	8/7/2019 3:20 AM
3	The program is relatively easy to use and covered content well.	8/5/2019 11:55 AM
4	Only added handwashing to competency, great time saver, overall improvement noted in clinical quality	8/2/2019 8:00 AM
5	Very informative and useful in educating and training staff. Aids in the successfully implementation of improved procedures to ensure better care based outcomes.	8/2/2019 6:12 AM
6	The tool kit saved time in developing this competency. It was also easy to use.	8/2/2019 6:08 AM

Q2 Please select the option that best defines your satisfaction with the Competency Tool-kit items:

Answered: 6   Skipped: 0
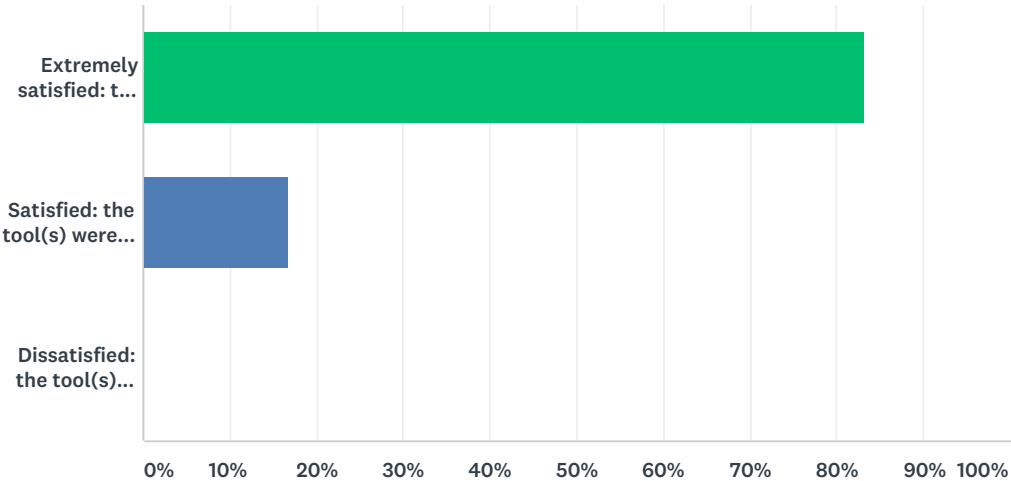
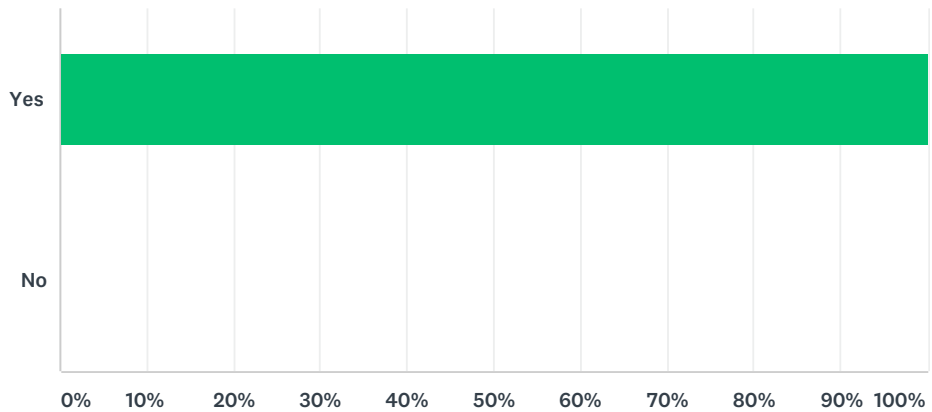| ANSWER CHOICES	RESPONSES	
Extremely satisfied: the tool(s) filled a need in our facility and helped to improve our competency based staff training program.	83.33%	5
Satisfied: the tool(s) were sufficient to supplement our current competency based staff training program.	16.67%	1
Dissatisfied: the tool(s) were inadequate and require improvement.	0.00%	0
TOTAL		6

Q3 If Dissatisfied in 2, please describe:

Answered: 0   Skipped: 6

#	RESPONSES	DATE
	There are no responses.	

Q4 Would you or other members of your nursing facility staff be interested in attending a Competency Certification Training Program if it were offered in your geographic area and costs of training were supported via the CMP grant fund project?
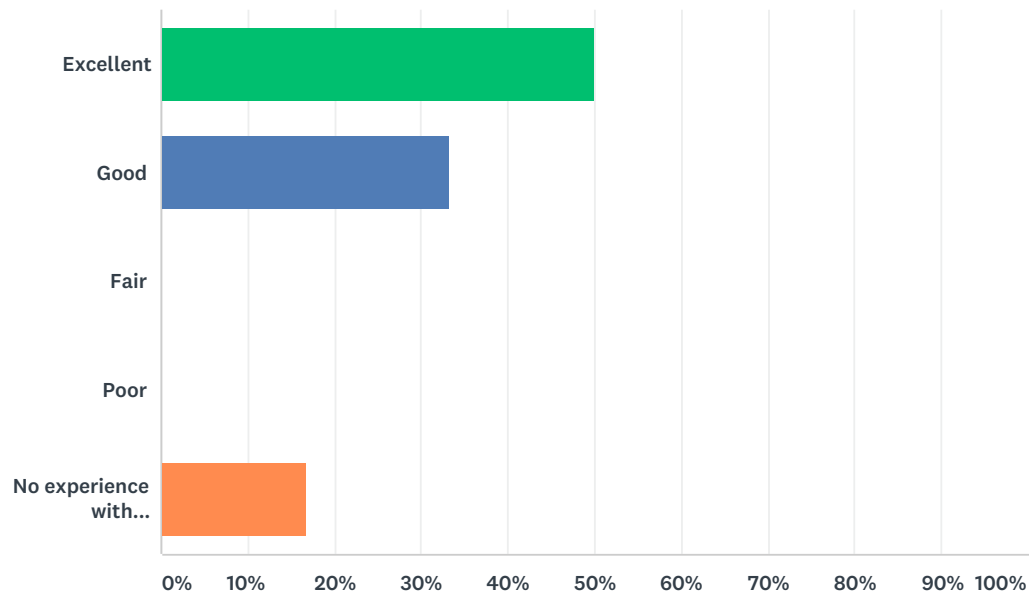
Answered: 6   Skipped: 0

ANSWER CHOICES	RESPONSES	
Yes	100.00%	6
No	0.00%	0
TOTAL		6

Q5 Please rate your overall experience with Proactive's training services including webinars, workshops and purchased staff development materials:

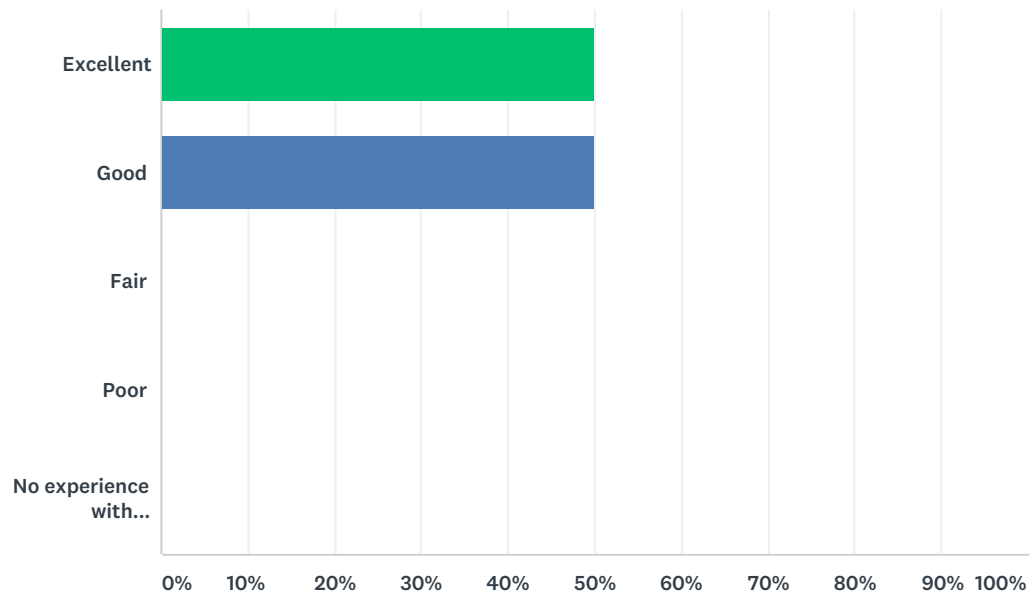Answered: 6   Skipped: 0

ANSWER CHOICES	RESPONSES	
Excellent	50.00%	3
Good	33.33%	2
Fair	0.00%	0
Poor	0.00%	0
No experience with Proactive's training services	16.67%	1
TOTAL		6

Q6 Please rate your overall experience with Proactive's tool-kits and resource items that you have accessed via the online shop or through training events:

Answered: 6   Skipped: 0

ANSWER CHOICES	RESPONSES	
Excellent	50.00%	3
Good	50.00%	3
Fair	0.00%	0
Poor	0.00%	0
No experience with Proactive's tool-kits and resources	0.00%	0
TOTAL		6

Q7 Please indicate any other feedback you'd like to share with us:

Answered: 2   Skipped: 4

#	RESPONSES	DATE
1	Not only were the toolkits great, but the staff was always helpful with questions when needed.	8/7/2019 12:50 PM
2	We appreciate all the hard work of Proactive in helping nursing facilities advance and improve. You have an excellent group of professionals.	8/2/2019 6:08 AM

Q8 Your Name/Title:

Answered: 6   Skipped: 0

#	RESPONSES	DATE
1	Wendy Weeler, MSN - Staff Development Coordinator	8/7/2019 12:50 PM
2	Shawn Thacker, BSN Staff Development Coordinator	8/7/2019 3:20 AM
3	Julie Harmon, RN, BSN Staff Development Coordinator	8/5/2019 11:55 AM
4	Teri Thompson, RN, Educator	8/2/2019 8:00 AM
5	Sandra K. Gay, Administrator	8/2/2019 6:12 AM
6	Alma Ahmetovic VP of HCS/HFA	8/2/2019 6:08 AM

Q9 Email:

Answered: 6   Skipped: 0

#	RESPONSES	DATE
1	Wendy.wheeler@ky.gov	8/7/2019 12:50 PM
2	shawn.thacker@ky.gov	8/7/2019 3:20 AM
3	julie.harmon@ky.gov	8/5/2019 11:55 AM
4	tthompson@chasecenterlogansport.com	8/2/2019 8:00 AM
5	sandy@whrv.com	8/2/2019 6:12 AM
6	almaa@swissvillage.org	8/2/2019 6:08 AM

Q10 Facility Name:

Answered: 6   Skipped: 0

| #	RESPONSES	DATE
1	KYDVA- Radcliff Veterans Center	8/7/2019 12:50 PM
2	Eastern Kentucky Veterans Center	8/7/2019 3:20 AM
3	Thomson-Hood Veterans Center	8/5/2019 11:55 AM
4	Chase Center	8/2/2019 8:00 AM
5	Western Hills Retirement Village	8/2/2019 6:12 AM
6	Swiss Village, Inc.	8/2/2019 6:08 AM

Q11 State:

Answered: 6   Skipped: 0

#	RESPONSES	DATE
1	KY	8/7/2019 12:50 PM
2	Ky	8/7/2019 3:20 AM
3	Kentucky	8/5/2019 11:55 AM
4	IN	8/2/2019 8:00 AM
5	Ohio	8/2/2019 6:12 AM
6	Indiana	8/2/2019 6:08 AM

Appendix J

First name	Last name	Company	Job title	Email address - other	Phone - other	Phone - work	Street address line 1 - Other	City - Other	State/Prov	Zip/Postal Code - Ot	Title	Association	Facility	Job	Updated At
Natalie	Barr	Crystal Care Centers	Director of Nursing	natalie@crystalcarecenters.com	4197472666		1159 Wyandotte Ave	Mansfield	Ohio	44906			Crystal Care Center of Mansfield		8/11/2019 21:23
Ragina	Channell		Corp Director of Nursing	rchannell@premierhcm.com	5135786200	5135614105	8700 Moran Rd	Cincinnati	OH	45244			Premier Health Care Manangement		8/13/2019 14:57
Casey	King	The Wesley Communities	Executive Director of Regulatory Compli	kking@thewesleyway.org	614-512-6639	614-888-7492	5155 N. High Street	Columbus	Ohio	43214			The Wesley Communities	Executive Director of Regulatory Complia	8/12/2019 14:09
Stephanie	Cleland	Middleport	Administrator	stephanie@overbrookcenter.com	7409926472		333 Page St.	Middleport	Ohio	45760		Ohio Health Care Association	Overbrook Center		8/12/2019 15:07
theresa	humenik		RN Corp QA	thumenik@windsorhouseinc.com	3305450195		29 East Liberty St	Girard	OH	44483	Quality Assurance		windsor House		8/19/2019 7:18
Katie	Mossbruger		Administrator	katie.mossbruger@jtslc.com	4407778444		27500 Mill Rd.	North Olmsted	OH	44070			Joshua Tree Care Center		8/12/2019 16:10
John	Ralphy		Administrator	jralphy@astoriaplacecincinnati.com	5139618881		3627 Harvey Avenue	Cincinnati	OH	45229			Astoria Place of Cincinnati		8/19/2019 6:26
MELISSA	BOMIA	Ursuline Center	Staff Development	mbomia@ursulinecenter.org	4195363535		4035 Indian Road	Toledo	OH	43606		Ohio Health Care Association	Ursuline Center of Toledo		8/14/2019 7:19
Jennifer	Tietsort	Williams County Hillside Country Living	Staff Educator	jtietsort@wmsco.org	419-636-4508		09876 County Road 16	Bryan	OH	43506		Ohio Health Care Association	Hillside Country Living		8/13/2019 10:05
Erica	Easley		Nursing Management	eeasley@enniscourt.com	216.226.3858		13315 Detroit Ave	Lakewood	Ohio	44107			Enniscourt		8/19/2019 22:27
Cynthia	Moore	Cincinnati	VP of Operations (corporate)	cmoore@cchhealthcare.com	513572850		1346 Lincoln Ave	Cincinnati	oH	45026		Ohio Health Care Association	Lincoln Crawford		8/9/2019 15:22
Kelli	Beckler		Assistant Administrator	kbeckler@wayneoh.org	330-262-1786		876 S Geyers Chapel Rd	Wooster	Ohio	44691			Wayne County Care Center		8/14/2019 8:44
TAMMY	DENTON		CEO	tdenton@stowglen.com	330-686-7100		4285 KENT ROAD	STOW	OH	44224			STOW-GLEN		8/9/2019 13:57
Kim	VanDenEynde		RN-DON	kim@merithousetoledo.com	419-478-5131		4645 Lewis Ave	Toledo	OH	43612			Merit House		8/13/2019 7:19
Candace	Reed	Elizabeth SCott	LNHA	creed@elizabethscott.org	419-724-5156		2720 Albon Rd	Maumee	OH	43537			Elizabeth Scott Community		8/20/2019 10:26
Melessa	Scattino	Assumption Village	Executive Director	melessa_scattino@mercy.com	330-729-2233		9800 Market Street	North Lima	Ohio	44452			The Assumption Village and Humility House		8/13/2019 13:43
Jennifer	Adams	MacIntosh	Corporate Director of Nursing	jennifer.adams@mmclp.com	6143459500		3863 Trueman Court	Hilliard	OH	43026			The MacIntosh Company - 7 facilities	Corporate Director of Nursing	8/12/2019 12:38
Shelly	Szarek-Skodny		Executive Director	sskodny@accordcc.com	4403968999		7250 Old Oak Boulevard	Middleburg Heights	OH	44130			ACCORD CARE COMMUNITY MIDDLEBURG HEIGHTS		8/13/2019 8:31
Lisa	Mitchell	Swanton Health Care & Retirement Center	CEO/Co-Owner	lmitchell@swantonhealthcare.com	4198251145		214 South Munson Road	Swanton	OH	43558		Ohio Health Care Association	Swanton Health Care & Retirement Center		8/13/2019 11:44
Rhonda	Charles		LNHA	rcharles@ursulinecenter.com	419-536-3535		4035 Indian Road	Toledo	OH	43606			Ursuline Center of Toledo		8/11/2019 14:39
Centra	Meyer		Director of Nursing	centra@leveringmanagement.com	740.369.6400		4 new market drive	Delaware	ohio	43015			Delaware Court Healthcare Center		8/9/2019 14:49
Jan	Miller	Wayne County Care Center	RN-RAC-CT	jmiller@wayneoh.org	330-262-1786		876 S. Geyers Chapel Rd.	Wooster	OH	44691		Ohio Health Care Association	Wayne County Care Center		8/12/2019 14:15

Appendix K
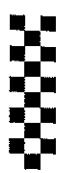
Crystal Care Nursing & Rehabilitation Center

1159 Wyandotte Avenue, Mansfield, Ohio 44906
(419) 747-2666

Medicare/Medicaid Approved
www.crystalcarecenters.com

Crystal Care Center

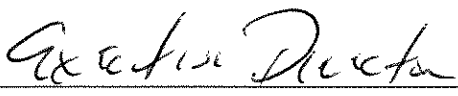### "Professionals in Long Term Care and Rehabilitative Services"

August 27, 2019

In the event Proactive Medical Review is awarded the grant for the Nursing Facility Competency Certification Program, our facility would be interested in implementing this competency program.

Respectfully submitted,

_____ RN D.O.N.
Signature

_____8/29/19_____
Title

MERCYHEALTH

The Assumption Village
9800 Market Street
North Lima, OH 44452
o: 330-549-0740
f: 330-549-0701
mercy.com

August 27, 2019

In the event ProActive Medical Review is awarded the grant for the Nursing Facility Competency Certification Program, our facility would be interested in implementing this competency program.

Respectfully submitted,

_____
Signature

_____
Title

August 27, 2019

In the event ProActive Medical Review is awarded the grant for the Nursing Facility Competency Certification Program, our facility would be interested in implementing this competency program.

Respectfully submitted,

Amanda Miller
Signature

Administrator
Title

www.OverbrookCenter.com

August 27, 2019

In the event Proactive Medical Review is awarded the grant for the Nursing Facility Competency Certification Program, our facility would be interested in implementing this competency program.

Respectfully submitted,

Stephanie Cleland, LNHA
Signature

Administrator
Title

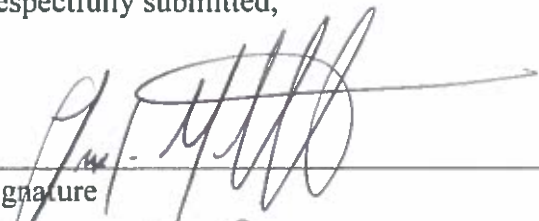333 Page Street • Middleport, OH 45760 • (740) 992-6472 • Fax (740) 992-7406

Scarlet Oaks

COMMUNITY

August 27, 2019

In the event Proactive Medical Review is awarded the grant for the Nursing Facility Competency Certification Program, our facility would be interested in implementing this competency program.

Respectfully submitted,

Cindy Moore
_____
Signature

VP of Operations (corporate)
_____
Title

August 27, 2019

In the event Proactive Medical Review is awarded the grant for the Nursing Facility
Competency Certification Program, our facility would be interested in implementing this
competency program.

Respectfully submitted,

Tammy L. Denton

Tammy L. Denton LNHA, CEAL, HSE
President & CEO

HSE
QUALIFIED
BY THE NAB

August 27, 2019

In the event Proactive Medical Review is awarded the grant for the Nursing Facility
Competency Certification Program, our facility would be interested in implementing this
competency program.

Respectfully submitted,

Signature

CEO/Co-Owner

Title

Ursuline Center of Toledo
4035 Indian Road
Toledo, Ohio 43606
419-536-3535
Fax: 419-536-3398

August 27, 2019

In the event Proactive Medical Review is awarded the grant for the Nursing Facility Competency
Certification Program, our facility would be interested in implementing this competency program.

Respectfully submitted,

Melissa Bomia
Signature

Staff Development
Title

Melissa Bomia, LPN
Staff Development
Infection control
Ursuline Center of Toledo

Windsor House Inc.

A Tradition of Caring Since 1959

101 West Liberty St. • Girard, OH 44420 • Phone (330) 545-1550 • Fax (330) 545-2444 • www.windsorhouseinc.com

August 27, 2019

In the event Proactive Medical Review is awarded the grant for the Nursing Facility
Competency Certification Program, our facility would be interested in implementing this
competency program.

Respectfully submitted,

Pamela M Hall RN
Signature

Corporate Staff Development Coordinator
Title
pamhall @ windsor house inc. Com

People • Caring • Commitment • Integrity

Windsor House at:
Burton • Canfield • Champion • Doylestown • Guardian • Liberty • Masternick Memorial
O'Brien Memorial • Omni Manor • Parkside • Snyder Memorial • St. Mary's Alzheimer's Center
Armstrong Memory Care Assisted Living • Champion Estates Assisted Living • Liberty Arms Assisted Living • Omni West Assisted Living • Windsor Estates Assisted Living

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