January 2020 | Volume 3, Issue No. 1

HCPro Advisory Services | PROPEL Long-Term Care Journal

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Use accounts receivable reports to uncover system and process issues that may lead to inaccurate claims

The phrase, "Cash is king" rings true for providers. Without positive margins and healthy cashflow, your ability to operate and provide excellent care to patients suffers. That's why many billers monitor the accounts receivable report (A/R) with an eye toward optimizing cashflow.

In these first few months of the Patient-Driven Payment Model (PDPM), billers need to be extra vigilant when reviewing the A/R report. The new payment model required massive changes to billing software programs as well as internal processes for completing the MDS. As providers navigate these changes, they face an increased risk for submitting inaccurate claims, says **Olga Gross-Balzano, CPA, NHA, PMP,** a manager with BerryDunn.

The A/R report is an excellent tool for identifying systems or process issues that prevent billers from submitting clean claims, says Gross-Balzano.

Variances or large balances on the A/R report can be warning signs that there is:

- An error in how your billing software calculates charges, payments, billed days, or submits the bill
- A breakdown in internal communications or processes

"If a biller sees a discrepancy on the A/R report, they must investigate it and find out whether it was an isolated incident or a much larger issue that may have a significant impact on cashflow," says Gross-Balzano.

Recognizing and resolving red flags on the A/R report is essential to financial success in the new payment environment says **Stefanie Corbett, DHA,** post-acute regulatory specialist for HCPro, Inc.

"With the implementation of PDPM, some facilities may project and book greater revenue, making it even more important to have effective A/R processes in place to quickly identify and resolve discrepancies that may impact cashflow," says Corbett.

Providers will surely be happy to see bigger margins, but it also means that they have more financial risk to man-age.

Resolving these errors protects your cashflow in the short and long term. On a daily basis, you know that your cash-flow

projections are accurate, which supports the SNF's operations. In the long-term, correct claims reduce the risk for reviews and audits.

Investigating what causes red flags on the A/R report can be daunting, but Gross-Balzano and Corbett reveal a few common culprits that providers should check as soon as they notice errors.

Validate system set up

Providers did a lot of work to prepare for PDPM, but billers and finance staff need to review the A/R report each month after posting to ensure there are no quality issues.

If you see large variances or balances, confirm the following is correctly set up in your billing software:

Medicare pricers. Review the A/R report and dig into why there are discrepancies between what you bill and what Medicare paid. Differences in reimbursement monies may be a sign that the system is not calculating charges or expected payments accurately.

This can either be an error in the software, but before reaching out to vendors, it's a good idea to confirm that you have the correct pricers and rates loaded into your system.

"I've seen many providers who have put the component base rates in the wrong order," says Gross-Balzano.

Medicare will process the claim with the correct pricers, and providers with misordered pricers will see a discrepancy in balances.

Billers should work with finance and IT teams to ensure the appropriate team loaded rates correctly.

If you confirm that you have the correct pricing rates in the system, reach out to your software vendor to further investigate and remedy the issue.

Number of billed days is accurate. Large variances on the A/R report may indicate an error in either how the system calculated or billed the number of co-pay days.

If you see balances more than $200-$250, check the number of days were both accurately counted and pulled onto the claim correctly, Gross-Balzano says.

Calculating the number of days covered by Medicare Part A is often straightforward, but billers should take extra care if a patient is subject to the Interrupted Stay Policy (ISP).

"The ISP is new with PDPM, and there is some confusion among providers with how to calculate and bill those days," says Gross-Balzano.

To ensure that days subject to the ISP are calculated and billed correctly Gross-Balzano suggests that billers:

- Understand how the ISP works and impacts a Medicare Part A-covered patient's benefit days. The ISP combines multiple SNF stays into a single stay in cases where the patient's discharge and readmission occurs within the three-day interruption window, according to CMS. The three-day interruption window starts with the calendar day of discharge and includes the two immediately following calendar days, ending at midnight.
- Ensure that whomever is responsible for updating the daily census understands the ins and outs of the ISP rules and knows how to apply those rules.
- Work with software vendors to understand how the software calculates days covered by the ISP. Some systems exclude the days depending on the census code entered (i.e, leave of absence, discharge and readmission, and bed hold), and others require you to manually calculate and enter the days.

If you confirm that the billing software accurately counted the number of covered days, but there is still an issue, check to see whether the system billed the days correctly.

For example, if a patient is admitted on September 30, Gross-Balzano has seen some systems erroneously count that as an unbilled day on the October claims.

Reduce overpayments. If your A/R aging report shows overpayments from Medicare, it could again be an issue with rate set up, miscalculated co-pay days, or incorrectly billed days.

Work with finance to resolve any systems issues causing overpayments because you will have to report those to CMS on the quarterly Medicare Credit Balance Report Form CMS-838.

"Any credit balances over $25 must be included on the report. CMS requires providers to list each claim, the amount of overpayment, and an explanation of why that money has to be paid back," Gross-Balzano says, adding that the next report is due in January. (Note: CMS instructions advise to "Submit a completed CMS-838 to your financial intermediary within 30 days after the close of each calendar quarter).

A pattern of overpayments may trigger a review or audit, so it's critical that billers flag and investigate the cause for overpayments that appear during their monthly review of the aging A/R reports.

Even if the credit balances on your A/R report do not exceed $25, billers still try to determine the cause of the issue to ensure it will not result in a larger compliance is-sue, Gross-Balzano says.

Update value-based purchasing adjustment files

Smaller balances or overpayments on the A/R report may also be a sign that you do not have the most up-to-date value-based purchasing adjustment loaded into your billing software.

In August 2019, CMS reported that they found an error in the calculation of the value-based purchasing adjustments and issued new files.

"Many providers have not loaded the most recent files from the Certification and Survey Provider Enhanced Reporting (CASPER) system. If you have the old files, the reimbursement on the claim may not be correct," Gross-Balzano says.

This is only the second fiscal year that CMS will issue value-based purchasing incentives. After CMS applies the market basket and QRP adjustments, it processes the value-based purchasing adjustment, says Corbett.

"MDSCs may access their facility's quarterly confidential feedback reports in the QIES and CASPER systems to determine their value-based purchasing adjustments," Corbett says.

CMS will update the adjustments annually. SNFs should have a process in place that alerts billers that the new re-ports are loaded in the system. This way, billers can ensure that the billing software processes the adjustments correctly.

Open the lines of communication

Changes to the MDS post-claims submission may also cause the A/R report to show substantial balances, variances in payments, and over payments.

If the MDS coordinator updates the MDS after the biller issues the claim, the A/R report will usually show a variance if the case-mix category for that patient changes and no longer matches what is on the claim, Gross-Balzano says.

Before PDPM implementation, it was probably safe to assume you could process the bill if the MDS coordinator submitted the MDS, and the system confirmed receipt and generated a Health Insurance Prospective Payment System (HIPPS) code. In these early days of PDPM, that may not be the case.

Billers should anticipate that MDS coordinators may make more changes to the MDS as they adjust to new PDPM requirements, Gross-Balzano says.

Proactively check in with MDS coordinators about the status of the MDSs. Before filing the claims and confirm that they do not plan to go back and revise them.

The triple check process provides a great way for billers to get a final confirmation from the MDS coordinator and other IDT members that all of the information on the claim is final and accurate, Corbett says.

However, many facilities either do not utilize the triple check as a best practice, but it is the best way for SNFs to prevent claims errors and mitigate financial risk.

The triple check is especially critical for SNFs that have remote or centralized billing offices where the billers may not have regular contact with MDS coordinators and other IDT members, Gross-Balzano says.

In such set-ups, the triple check may really be the only time that the biller can validate the information on the claim with all stakeholders.

Although billers should look out for these warning signs as the industry transitions into PDPM, they should always dig deeper into line items on the A/R report that do not look or feel quite right.

CMS updates the Medicare rates and pricers and value-based purchasing adjustment files on a regular schedule, which may cause these same issues and put your cashflow at risk. ■

PIP launch checklist

CMS provides a *checklist* to ensure that SNFs cover all of their bases when chartering a PIP team.

Project stakeholders and team members

- ☐ *The team has received a project charter that has been approved by the leadership.*
- ☐ *The project team has been assembled and roles and responsibilities have been assigned.*
- ☐ *The project charter is understood and accepted by all project team members.*

- ☐ *The project team understands how the project fits with the overall goals of the organization.*
- ☐ *Each project team member understands how his/her assignment fits into the overall project.*
- ☐ *The project and its goals have been communicated to stakeholders outside of the project team, as needed (e.g., residents and families, staff, board of directors, owners).*

Project resources

- ☐ *Financial support for the project has been obtained.*
- ☐ *A project budget has been established.*
- ☐ *Staff time to work on the project has been allocated.*
- ☐ *Material resources required for the project have been identified and secured.*

Project process

- ☐ *A detailed timeline and work plan have been created.*
- ☐ *Training needs have been identified and training has been conducted.*
- ☐ *A schedule for regular project team meetings has been set.*
- ☐ *Indicators/measures have been established to monitor project goals (see Goal Setting Worksheet).*
- ☐ *The format and frequency for documenting project status has been defined.*
- ☐ *The format, frequency, and audiences for communicating project status has been defined.*
- ☐ *A process to identify issues that come up during this project is established (e.g., unintended consequences, new opportunities for process changes, surprises).*
- ☐ *The location for storing all project documents, and processes for file naming conventions and version control has been established.*
- ☐ *The time for project kickoff has been identified and any related activity required (e.g., announcement, meeting, event) has been planned.*

Disclaimer: Use of this tool is not mandated by CMS, nor does its completion ensure regulatory compliance. ■

QAPI deep dive

Utilizing PIPs and RCAs to address deficiencies

A successful Quality Assurance and Performance Improvement (QAPI) program isn't complete without Performance Improvement Projects (PIP) with specific charters. As an integral part of any QAPI program, the usage of PIP teams directly affects star ratings, according to **Maureen McCarthy, RN, BS RAC-MT, QCP-MT, DNS-MT, RAC-MTA,** president and CEO of Celtic Consulting.

State survey agencies (SSA) require that SNFs show documentation of an active QAPI program with PIP teams assigned to address issues within the facility. When a SNF is actively attempting to correct an issue through a PIP, SSAs cannot give a citation for the issue being addressed, according to McCarthy.

Chartering a PIP team

When seeking a problem for a PIP team to focus on, SNFs should review their quality data to look for trends such as an increase in resident falls or pressure ulcers, according to McCarthy, who stresses the importance of being proactive rather than reactive. Charter a PIP before an issue arises if it's been a problem for the facility in the past.

PIPs should focus on three categories of issues, says McCarthy:

- High-volume problems: issues that affect a large number of residents, but don't typically have severe outcomes (e.g., food being served cold)
- High-risk problems: issues that affect individuals, and can often have severe outcomes (e.g., falls, pressure ulcers, infections)
- Problem-prone: issues that constantly cause a problem, but not necessarily harm (e.g., documents not being signed at late-night admissions)

One of the most prevalent issues that should be addressed in a SNF is resident falls, according to **Megan Reavis**, instructor and founder of MCR Seminar, LLC, a company that hosts on-site training seminars for the medical community. Falls are a good issue to focus on, as they are common and can be the result of something obvious (e.g., obstacles on the ground) or something obscure (e.g., poor lighting or loose handrails).

Resident input should also be considered when deciding which project a PIP should focus on, says McCarthy. For example, complaints of cold food could be an easy problem to resolve and one that would likely lead to higher resident satisfaction.

Once a problem is identified, a PIP team should be created to address it. The PIP team should include the facility administrator, director of nurses, infection preventionist, and medical director, as well as two non-managerial staff members, such as a CNA and dietary aide, says McCarthy. *CMS notes* that residents and family members are also allowed to be members of PIP teams; however, they may not be allowed to know certain private resident information under HIPAA.

CMS provides a *worksheet* outlining the roles and responsibilities that should be included in a PIP team:

- *Project Sponsor - Provide overall direction and oversee financing for the project*
- *Project Director - Coordinate, organize and direct all activities of the project team*
- *Project Manager - Manage day-to-day project operations, including collecting and displaying data from the project*
- *Team Members - Choice of team members will likely be deferred to the project manager based on interest, involvement in the process, and availability*

When a PIP team investigates an issue within the facility, PIP members should document important information about the event. According to Reavis, PIP team documentation should answer the following questions:

- When did the event take place?
- Where did it take place?
- Who was there when it happened?
- Are there any patterns in this type of event?
- Are there structures currently in place to prevent the event?

This documentation is important, because SSAs will ask to see proof of a QAPI program that includes PIPs during survey periods.

While PIPs in action can look very different depending on the issue being addressed, CMS offers guidance for PIP teams in *QAPI at a Glance*:

- Consider each PIP a learning process
- Determine what information you need for the PIP
- Determine a timeline and communicate it to the Steering Committee
- Identify and request any needed supplies or equipment
- Select or create measurement tools as needed
- Prepare and present results
- Use a problem-solving model like PDSA (Plan-Do-Study-Act)
- Report results to the Steering Committee

Conducting a root cause analysis

After a PIP team has completed the project, a root cause analysis (RCA) should be conducted by the PIP team investigating the specific issue, says McCarthy. The purpose of this is to understand the underlying causes of a problem, and incorporate that knowledge into the solution, *according to CMS.*

There are *seven steps* CMS recommends PIP teams take when conducting an RCA:

1. *Identify the event to be investigated and gather preliminary information*
2. *Charter and select team facilitator and team members*
3. *Describe what happened*
4. *Identify the contributing factors*
5. *Identify the root causes*
6. *Design and implement changes to eliminate the root causes*
7. *Measure the success of changes*

CMS suggests using a strategy called "*The Five Whys*" to get to the root of an issue. Despite the name, it won't always take five whys to get to the root—it can take more or less, depending on the depth of the issue. CMS uses the following everyday *example* to illustrate how SNFs should use the Five Whys to find a root cause:

1. *Why did you get a flat tire?*
   - *You ran over nails on the garage floor.*
2. *Why were there nails on the garage floor?*
   - *The box of nails on the shelf was wet; the box fell apart and nails fell from the box onto the floor.**
3. *Why was the box of nails wet?*
   - *There was a leak in the roof, and it rained hard last night. (Root cause=leak in the roof)*

*If you stopped after the second "why" and resolved the problem by sweeping up the nails, you would have missed the root cause of the problem, so it's important to follow through to the end.

McCarthy cites an RCA example she encountered after a PIP team was chartered to address an increase in pressure ulcers: The SNF noticed that pressure ulcers doubled one month, then tripled the following month. The increase in pressure ulcers resulted from residents not being repositioned frequently enough; however, this was not the root cause of the issue. Upon investigation, the root cause was found to be staff calling out of their shifts. The RCA uncovered that CNAs were assigned too many duties and didn't have time to properly reposition residents. Stressed CNAs were calling in sick to work, creating even more work and less time for the CNAs on duty. The solution to this problem was to spread out the task of rotating residents to a larger number of staff, so that CNAs would not be overworked and tempted to call in sick.

Once the root cause of the issue is identified, the results should be shared with staff facility wide, says McCarthy. As QAPI programs should be ongoing and evolving, McCarthy suggests that SNFs incorporate results into their staff training, to prevent issues from arising again. ■

ADR process must change to reflect PDPM's clinical focus

Clinical characteristics of patients rather than the volume of services provided drive reimbursement in The Patient-Driven Payment Model (PDPM). It only makes sense then that auditors will now conduct a more clinical-focused pre- and post-pay medical review.

"The additional documentation request (ADR) process under PDPM is going to be like no other audit program we've ever known before," says **Reta Underwood,** Medicare specialist and president of Consultants for Long Term Care.

To attain accurate PDPM reimbursement, SNFs must ensure the medical record and MDS completely capture the patient's acuity. As such, auditors will review the medical records with much more scrutiny than they did in RUG-IV, says Underwood.

However, many providers have not updated their ADR processes for PDPM, leaving them unprepared should a review entity conduct a pre- or post-pay review.

The process is no longer as simple as cross-referencing therapy minutes listed on the MDS with those in the service logs as was the process in RUG-IV.

If you're not ready to back up all of the clinical data included on the MDS, you increase the likelihood that the review entity will re-coup or deny payments, says Underwood.

The good news is there is time to prepare. With just a few months of claims submitted in the PDPM system, medical review entities are likely just starting to get the audit wheels turning. Now is the perfect time to create or up-date your ADR process to make it PDPM ready. Reviewing and updating your process will increase your chances of a favorable outcome and ultimately protect your revenue integrity.

Know what auditors will look for

An ADR is a request for medical records so that auditors can conduct a medical review and determine whether a claim should be paid. The first step in updating your ADR process to consider what auditors will now look for in the new reimbursement model. Because audits in the new reimbursement system are new for everyone, it's impossible to predict exactly what auditors will focus on. However, you can use what you do know about PDPM to make some pretty good guesses, Underwood says.

The Final Rule says that anything on the MDS that generates the Health Insurance Prospective Payment System (HIPPS) code should be included in the plan of care.

"If I'm an auditor and want to make sure the claim is justified, I'm going to look at the pieces that drove the HIPPS calculation and how it's incorporated into the care plan, and cross-reference that everything is on it," Underwood explains.

From there, Underwood expects auditors to review the daily skilled notes to ensure all the clinical conditions and services provided were described in the medical record.

Auditors will also scrutinize the ICD-10 codes coded on the MDS and claim. Accurate PDPM reimbursement re-quires SNFs to provide clinical documentation detailing the patient's clinical acuity and precise ICD-10 codes that reflect those conditions.

Medical record documentation submitted in response to an ADR must support the ICD-10 codes

coded on the MDS, especially those related to major reimbursement drivers, such as the primary diagnosis, co-morbidities (CC) that impact the non-therapy ancillary, and nursing component, Underwood says.

Although PDPM reimbursement relies on clinical documentation and ICD-10 coding in a way that SNFs have never experienced before, there are a few audit triggers that remain the same in PDPM.

Auditors will continue to look for documentation showing medical necessity and that the patient met the requirements for a skilled level of care. Those criteria do not change in PDPM, Underwood says.

It's also important to note that many of the same requirements that triggered a technical denial in RUGs-IV will continue to do so in PDPM, says **Stacy Baker, OTR/L, CHC, RAC-CT,** director of audit services for Proactive Medical Review & Consulting, LLC.

SNFs must continue to have in the medical record:

- Physician certifications/re-certifications completed accurately based on guidance from Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, "Physician Certification and Recertification of Services," §§40 - 40.6
- Proof of physician visits as outlined in 42 CFR, 483.40 Physician Services
- Documentation from the hospital stay supporting those conditions that require extended care in the SNF

The shift to reimbursing SNFs based on the clinical acuity of patient and the importance of clinical documentation makes it impossible to respond to an ADR without input from the interdisciplinary team (IDT).

Involve the IDT

In order to win a favorable ADR adjudication in PDPM, the IDT needs to conduct an in-depth review of the clinical documentation included in the submission packet to:

- Ensure documentation supports all conditions and services reported on the MDS, especially sections that drive reimbursement. In RUG-IV, 33 MDS items impact payment, but in PDPM, there are well over 100 items on the MDS that can potentially impact payment, Baker says.
- Confirm ICD-10 codes are accurate and comply with RAI Process coding guidelines, Underwood says.

This is a major shift from the RUG-IV system in which many SNFs relied on billers to collect the material for the submission packet. For PDPM, providers need to update their policies to include the IDT, says **Barbara Reimer,** consultant with the Fox Group.

"Billers or other non-clinical staff may not understand what parts of the clinical records will best support billed services, or what clinical documentation the medical re-view entity wants to see," says Reimer.

Additionally, providers who relied on therapy contractors to respond to ADRs, should consider bringing the ADR process in-house because therapy is only one small piece of what auditors will look for, says Underwood.

In PDPM, it is imperative for clinical staff to play a more active role in determining and reviewing the medical records and contributing to supporting materials (i.e., cover or statement letters) sent in the ADR packet. Clinical staff, especially the MDS coordinator and nurse assessment managers, know what documentation is required to support the MDS and can include it in the documentation packet submitted for review.

Update your documented ADR process to formally out-line the IDT team members who may participate in the ADR response and their responsibilities, says Under-wood.

IDT team members who may participate in the ADR process include:

- MDS coordinators
- Therapy providers
- Nursing staff
- Social Services / Case management
- Dieticians/dietary staff
- Physicians and/or nurse practitioners

The clinical IDT should review the records prior to submitting to the review entity and determine whether the SNF should include additional clinical information not included in the formal request but will support the services provided, Reimer says.

In addition to clinical staff, consider listing that compliance officers, medical records staff, and administrators will be called on as needed to facilitate the ADR response.

Designate a person to receive and check for ADRs

SNFs may receive an ADR from any one of several medical review entities (i.e., CERT, UPIC, RA, MACT, TPE Notification letters) that may notify you via fax, postal mail, or electronic systems, Baker says.

"You do not want to have a recoupment because the notice was in the wrong mailbox or set aside by someone who did not understand it's purpose," Baker says.

The designated person should check the Direct Data Entry at least weekly to see if there are any suspended claims with a request for an ADR in the system. You can see claims with an associated ADR under location S B6000 or S B6001 of the DDE, says Reimer.

It's also a good idea to make anyone who checks the mail, fax, or email aware of what ADR correspondence looks like so that they can deliver it to the correct individual in case the review entity sends the notice to a general inbox, address, or phone number.

Identify a back-up person to receive ADR requests in case the primary person is out of the office, especially if he or she is taking extended leave (e.g., maternity or paternity leave).

Select a person to project mange the ADR response process

The person identified may be someone from billing or the business office, medical records, or a member of the clinical team, such as the MDS coordinator. The individual will:

- Request the medical record
- Distribute the medical record and ADR information to the appropriate member of the IDT for review
- Coordinate meetings to discuss the response
- Track and help gather additional documentation IDT members determine should be included in the submission packet
- Sets hard deadlines and follows up with all team members to ensure the on-time completion of reviews and deliverables, such as the cover letter
- Reviews the packet to verify all information requested is included and that it is well-organized (see next section for organization tips)
- Mails, faxes, or submits the packet as indicated by the review entity

The importance of this role cannot be emphasized enough. Effective project management is critical to meeting the turnaround requirement specified in the ADR. Check with the review entity, but most require you to send the records within 45 days.

If you do not submit the packet within that timeframe, you will receive an automatic denial. Additionally, the more quickly you submit the documentation for review, the quicker you will receive a response and payment during pre-payment reviews. If favorable, you'll know that you can keep that payment, Baker says.

Create tools to ensure you have all the information required for an ADR

Enlist the help of the MDS coordinator or other members of the IDT to create a few tools that will facilitate the collection and review of documentation that must be submitted in the ADR, suggests Underwood.

Consider creating:

- Medical record outline that describes where critical information is in the medical record.
- Checklist of documentation that each member of the IDT should either review or ensure is in the file

With a solid ADR process in place, you know the right people are involved in contributing to the materials in the submission packet. However, if your packet is confusing or difficult for the auditor to read, you may hurt your chances of a favorable outcome.

Submit a well-organized packet

ADR submission packets should be well-organized so that the reviewer can open it up and find the key records that support the claim with ease.

Baker recommends that SNFs organize the documentation behind a cover letter in the following order:

- Physician oversight documentation, including SNF certification/recertification, progress re-ports, signed/dated orders. Additionally, the cover letter should highlight the physician's support of all active conditions reported in Section I of the MDS because patient conditions are the primary driver for reimbursement under PDPM.
- MDS assessment(s), followed by other critical records that are clearly identified such as care plans, nursing notes and assessments, medication and treatment records, diagnostic testing, etc.

- Therapy documentation, including evaluation, progress reports, discharge summary, daily treatment notes, and service log matrix
- Other patient-specific information pertinent to the review such as hospital records including proof of surgical procedure(s), and other conditions potentially captured in the look-back period.

"We find that organizing the letter by bullet points and noting specific documentation found in the record to support the HIPPS code is best," Baker says.

Also ensure that the documentation is legible. This means any handwriting (if present) can be read, and that all photocopies are clear and facing in the same direction.

When you send the packet, maintain a copy for your records and keep email and fax confirmations that you sent it.

Once you submit your packet, it may feel like your job is done. However, it's a good idea to investigate what may have triggered the ADR. If there is a systemic issue, involve the appropriate individuals to address it so that you do not receive additional ADRs, an outright denial or targeted review later down the road, Underwood says. ■

Tip & tool

Cultivating a culture of trauma-informed care

Because SNFs are occupied by residents with varying backgrounds, there can be many kinds of trauma lurking in their pasts. Trauma-informed care aims to create an understanding of the role trauma plays in a resident's well-being, *according to CMS*. "The most healing thing we can do for one another in a trauma-informed environment is to make a positive personal connection," says **Gigi Amateau, MSG,** of the Virginia Commonwealth University Department of Gerontology.

What is trauma?

Trauma stems from a past event that negatively affects a person physically or emotionally. It affects people of every race, age, gender, ethnicity, sexual orientation, psychosocial background, and geographic region, according to the *Substance Abuse and Mental Health Services Administration* (SAMHSA) in *Trauma Informed Care in Behavioral Health Services*. Providing trauma-informed care to residents plays a vital role in ensuring resident well-being, as well as promoting safety, trustworthiness, choice, collaboration, and empowerment, *according to CMS*. Trauma can manifest in different ways, and the behavioral symptoms can often be misidentified and medicated as mental disorders, says **Stefanie Corbett, DHA,** postacute care regulatory specialist at HCPro.

Rather than automatically resorting to medication to deal with a resident's behavior, "[SNFs] need to illuminate the root cause of the behavior. In some cases, it very well may be because of a mental disorder, but it could also be a layered effect of dealing with past trauma," explains Corbett. This is why trauma screenings are so important.

Trauma screening

A comprehensive trauma screening should take place at admission for every resident and be documented in medical records, says Corbett. Before the formal screening takes place, though, it can be beneficial to have an open conversation about past trauma with residents in a casual, nonthreatening environment, says Amateau. Topics discussed in this initial conversation can include such things as what makes residents sad, anxious, or stressed, and their personal coping methods, Amateau notes.

While a social worker or a nurse can conduct the screening, Corbett recommends that a social worker do so, then work in tandem with a nurse when caring for a resident if trauma is identified. If a facility's social worker isn't licensed, then a nurse should conduct the screening.

The most important areas to screen for when dealing with residents with past trauma, as outlined by Corbett, include:

- Trauma-related symptoms
- Depressive symptoms
- Sleep disturbances
- Past and present mental disorders, including trauma-related disorders
- Type and characteristics of trauma
- Substance abuse
- Social support, coping styles, and availability of resources
- Risks for self-harm, suicide, and violence
- Health screenings

When conducting screening and assessments, there are 10 general guidelines staff can follow, according to Corbett.

1. Ask residents about any history of trauma
2. Use only validated tools when screening and assessing residents
3. Screen residents with past trauma for psychological symptoms and mental disorders related to the trauma
4. Screen residents with past trauma for suicidal thoughts and behaviors
5. Screen for trauma upon admission, rather than waiting for symptoms to show
6. Focus assessments on how trauma affects a resident's current state of being
7. Consider using pencil and paper when conducting screening and assessments, as it can be less threatening to residents than a clinical interview
8. Explain to residents how the findings will be used in planning treatment, and make sure the resident is in a safe space mentally prior to exiting the interview
9. Understand that some residents won't make a connection between past trauma and current patterns of behavior
10. Don't further traumatize residents by requiring them to describe emotionally overwhelming traumatic events in detail

SAMHSA provides free screening tools that can be used by SNFs when conducting resident screens. Although the tools aren't specifically designed for SNFs, Corbett asserts that they are applicable to the long-term care environment. SAMHSA *screening tools* are offered for:

- Sample screening
- Depression
- Drug & alcohol use
- Bipolar disorder
- Suicide risk
- Anxiety disorders
- Trauma

Compliance with Phase III

Implementing trauma-informed care in facilities is mandated in the Requirements of Participation Phase III; it does not, however, prescribe any specific training that needs to take place. SNFs should review the training in-services they already have in place to find lessons that may align with trauma-informed care, and adopt a similar model of training, according to Amateau.

Amateau recommends giving all staff within a SNF beginner training to provide a foundation for understanding trauma and resilience and the role it plays in every person's lives.

"The most healing thing we can do for one another in a trauma-informed environment is to make a positive personal connection."

-Gigi Amateau, MSG.

Trauma screening is not only an important aspect of providing comprehensive care to residents—it's also absolutely necessary for compliance. "A trauma screening is a dead giveaway for surveyors on whether or not SNFs have truly implemented trauma-informed care as a part of their facility's culture," says Corbett. CMS surveyors will use the Behavioral and Emotional Status Critical Element Pathway to determine compliance. Noncompliance with this regulation can result in citations under several F-tags. According to Corbett, noncompliant facilities can potentially receive citations for any (or several) of the following F-tags:

- F659—Qualified persons/comprehensive care plans
- F699—Trauma informed care (effective 11/28/2019)
- F741—Sufficient competent staff, behavioral health needs
- F740—Behavioral health services

Questions Comments & Ideas

– Tami Swartz, Member Liason
tswartz@hcpro.com

- F742—Treatment/services for mental-psychosocial concerns
- F743—No pattern of behavioral difficulties unless unavoidable

The seven domains of trauma-informed care

In order to create a successful trauma-informed care plan, there are seven domains that should be followed, as outlined by Corbett:

- **Domain 1:** Early Screening and Comprehensive Assessment—Develop and implement a respectful screening and assessment process that is routine, thorough, culturally relevant, and sensitive.
- **Domain 2:** Patient-Driven Care and Services—Involve and engage patients to meaningfully participate in planning, implementing, and evaluating improvement efforts.
- **Domain 3:** Trauma-Informed, Educated, and Responsive Workforce—Increase the awareness, knowledge, and skills of the entire workforce to deliver services that are effective, efficient, timely, respectful, and person-centered. Implement policies, procedures, and practices that build and sustain a trauma-informed work force.
- **Domain 4:** Trauma-Informed, Evidence-Based, and Emerging Best Practices—Increase awareness, knowledge, and skills of the clinical workforce to deliver research informed treatment services that address effects associated with trauma and honor the core principles of trauma-informed care.
- **Domain 5:** Safe and Secure Environments—Increase the awareness, knowledge, and skills of the workforce to create safe, trusting, and healing environments. Examine and change policies, procedures, and practices that may unintentionally cause distress and re-traumatize patients.
- **Domain 6:** Community Outreach and Partnership Building—Recognize that patients are part of and affected by other systems, and thus assume a leadership role in educating and engaging partners in trauma-informed care.
- **Domain 7:** Ongoing Performance Improvement and Evaluation – Ensure a system is in place to measure performance in each domain. Track, analyze, and review data to address challenges and/or reinforce progress. ■

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QUESTIONS? COMMENTS? IDEAS?
Contact Member Liason **Tami Swartz** at tswartz@hcpro.com or 781-639-1872, Ext. 3352.

*PROPEL***Long-Term Care Journal** (ISSN: 2576-4411 [online]), the newsletter of *PROPEL***Long-Term Care**, is published monthly by HCPro, a Simplify Compliance brand. *PROPEL***Long-Term Care Journal**, 35 Village Road, Suite 200, Middleton, MA 01949.

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100 Winners Circle, Suite 300, Brentwood, TN 37027