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SHORTS ON LONG TERM CARE

for the North Carolina LTC Community from Poyner Spruill LLP

Growing Old Ain't for Wimps

by Ken Burgess

As the saying goes, growing old ain't for wimps, and caring for aging Americans also ain't for wimps these days, with the passage of health reform. The Patient Protection and Affordable Care Act (PPACA) passed earlier this year includes several nettlesome provisions for providers caring for elderly patients or residents, including:

- The Elder Justice Act: From reporting of "suspected crimes" to establishing various governmental advisory boards and councils, this section of PPACA establishes multiple new legal obligations for long-term facilities, but also establishes several new programs or grants to enhance long-term care with a focus on reducing abuse, neglect, and exploitation. The programs relate to various areas in long-term care, such as staffing, adult protective services, and research. Many of these provisions are effective now with little or no guidance from the government.
- New Transparency Requirements: PPACA mandates the revelation of significantly more invasive information about owners, managers, governing body members, and other "additional disclosable parties" of regulated facilities. A facility will have to certify that the information is accurate and current or face penalties. A standardized format for this information (along with some analysis of what information is needed) is due out by March 2012, but you must have this information (whatever it may be) available now if the government pays your facility a visit.
- Fraud and Abuse Changes from the Escrow of Civil Monetary Penalties (CMPs) and New Grounds for Exclusion: PPACA establishes various new grounds for exclusion and CMPs, as well as increased penalty thresholds for existing CMPs. The real kicker is that because of PPACA, CMS can collect a large CMP from you and keep that money in an escrow account until all appeals are exhausted. How's that for a drain on cash flow? PPACA permits a facility to reduce a CMP by 50% in some situations, but this reduction is for specific nonserious violations and is bogged down by many, many caveats and limitations. PPACA also provides for the independent informal dispute resolution of CMPs, another change that sounds good until you read all the restrictions and pitfalls associated with this process, including its "pay to play" provisions under which providers who elect to use this "independent" process must pay for the costs of conducting it.
- Mandatory Compliance Programs: If you haven't done so already, your facility will need to have a compliance and ethics program in place by March 2013. You can (hopefully) expect some amount of additional governmental guidance in the coming months. For now, CMS has issued a call for comments and suggestions on what should be required in SNF compliance programs and has awarded a federal contract to a group of researchers and industry experts to develop recommendations for SNF compliance and ethics programs.

These are just a few of the new governmental efforts focused on long-term care providers in health reform. While PPACA does include several workforce programs and grants that may actually benefit providers over the long haul, the law also contains many provisions that are punitive and burdensome (in terms of administration, staffing, and finances). The law also contains a plan to develop incentives for individuals to purchase long term care insurance, with somewhat limited per-day payment rates to facilities. Some have noted the irony of the Obama administration providing to the long term care industry another insurance-related product in legislation touted as curing abuses in the health insurance industry.

Ken Burgess of the Poyner Spruill health law team is serving on the Institute of Medicine Health Law Reform Fraud and Abuse task force charged with making recommendations to the N.C. Department of Health and Human Services about changes in state law, regulations and/or policies required to comply with various aspects of the reform legislation's fraud and abuse provisions. Currently, the task force is identifying all relevant fraud and abuse provisions in the reform legislation, determining which of these provisions require corresponding state laws or regulations, and determining whether North Carolina already has compliant statutes, regulations or policies and, if not, what changes need to be made. We'll keep you posted on the work of the IOM task force.

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FutureCare of North Carolina – A New Voice for Change in Long-Term Care

By Gordon DeFriese, PhD

In 2007, the North Carolina Health Care Facilities Association, the trade association for skilled nursing care facilities in the state, saw the need for a new research and education initiative that would focus on efforts to address the many issues affecting the quality and performance of the nursing home industry, with an emphasis on innovative approaches to long-standing issues in both medical/nursing care as well as in residential quality of life. The decision to form a new nonprofit 501(c)(3) public corporation, with its own independent board of trustees, would make it possible to attract to North Carolina support from a variety of private philanthropies and governmental agencies so that these efforts could focus on all types of facilities providing skilled nursing care.

The wisdom of this initiative, taken under the leadership of J. Craig Souza, the President of the North Carolina Health Care Facilities Association, was almost immediately successful in attracting nearly $300,000 in private financing from The Duke Endowment for the support of an innovative (perhaps even unique) approach to in-service education for nursing home nursing personnel at every level (NAs, LPNs, and RNs). Through this project, directed by Polly Godwin Welsh, RN-C, FutureCareNC was able to purchase a $75,000 patient care simulator (mannequin) that would make it possible to simulate almost any bodily function. And with the aid of a dedicated nurse educator, Mandy Richards, RN, MSN, who travels with the mannequin, FutureCareNC was able to offer on-site simulated practice in the recognition of critical clinical symptoms and medication reactions, and to enable all nursing teams in each of 40 participating facilities not only to gain experience in both the recognition of such clinical signs and symptoms, but to also learn how to intervene appropriately, including to practice communication skills associated with reporting among nursing team members and with physicians and families.

This has proven to be one of the most exciting and highly acclaimed approaches to in-service nursing education offered in skilled nursing care facilities in our state. The project is so successful that it is now proposed that this same approach be made to a series of medication-related errors that are most common in the management of skilled nursing patients. Moreover, several companies operating nursing facilities in our state have made it known that they are interested in providing patient care simulators for regular in-service education program use in their facilities, and FutureCareNC is offering to train-the-trainers in the use of these new approaches to nursing skill development.

Beyond this initial project, FutureCareNC is also facilitating an innovative new demonstration in multiple facilities whereby a nurse aide is being trained in the provision of simple oral health care (brushing patients' teeth) for those who are unable to do this for themselves. This project, first attempted in a New England state, is already receiving rave reviews from those facilities within which it has been initially introduced. Once the demonstration project is fully implemented, a DVD will be prepared so that its results can be more widely disseminated among all skilled nursing facilities in the state. This project is expected to have many dental as well as medical/nursing benefits, e.g., a reduction in the incidence of aspiration pneumonia and the enhancement of personal self-esteem and nutrition associated with the experience of good oral hygiene for those residents who will benefit from this innovation.

FutureCareNC staff are also working to bring together all important stakeholders with an interest in the use of nurse practitioners in long-term care. Building on the excellent results obtained from the early demonstration of the utility of nurse practitioners in skilled nursing care in Wilkes Senior Village in North Wilkesboro, FutureCareNC expects that many other North Carolina skilled facilities will want to realize the potential benefit in terms of lowered rehospitalization and lowered rates of medication errors as nurse practitioners become part of the nursing care team in these facilities.

These are only some of the projects FutureCareNC has either under way or in the planning stages. We hope you'll take the opportunity to learn more about FutureCare at upcoming association events and FutureCare events, and to get involved in this exciting foundation. It is the intent of FutureCareNC to begin to systematically address issues for which carefully constructed demonstrations can be undertaken in a few skilled nursing facilities and the results then implemented more widely in others, as North Carolina's nursing home industry moves forward in its aspiration to achieve recognition as the national best.

The FutureCare board of directors consists of leaders from the long term care industry, hospital industry, insurance industry, and academia. The Foundation's president is Dr. Gordon DeFriese, former president of the N.C. Institute of Medicine and the board of directors is chaired by Ken Burgess of Poyner Spruill.

ASSISTED LIVING COMMUNITIES

Toss or Keep: Document Retention in a Nursing Facility

By Ken Burgess and Kristi Huff

Deciding how long to hold on to specific records in your facility can be a challenging task, especially when so many different types of records cross your desk every day. If you're a pack rat like us, it's tempting to hold on to everything indefinitely – an option we know can be space and cost-prohibitive, especially within the nursing home environment. Our reluctance to dispose of records is also driven by several critical questions, such as: What if I need this record to defend our facility in a lawsuit? What if a state or government agency audits or investigates our facility for issues contained within this record?

This is why it makes sense from a compliance and risk management standpoint to have a comprehensive and consistently applied record retention policy that includes all forms of electronic data. There are many reasons to implement a record retention policy, including compliance with statutory or regulatory requirements, maintaining control of records during litigation and improving your responsiveness and efficiency in complying with discovery demands, and avoiding the disclosure of unnecessary or obsolete records.

An effective policy will also help you avoid liability for any inadvertent destruction of evidence when litigation or a government investigation is pending or reasonably foreseeable, such as when a subpoena has been served. Generally speaking, anytime your organization is aware (or should have been aware in the exercise of reasonable diligence) of a pending dispute like an audit, investigation or lawsuit, you will be required to retain any record potentially related to the matter. For this reason, you'll want to make sure that your record retention policy includes procedural steps for preserving relevant evidence and instructing employees not to delete or destroy relevant records (such as placing a "Litigation Hold" on records that are the subject of an investigation or lawsuit). As recent court cases illustrate, organizations can be subject to large sanctions for the destruction of records when litigation, government investigations, or other disputes are, or should have been, anticipated. If you inadvertently and in good faith dispose of relevant records as part of your fully implemented, consistently applied, active records management program, you are more likely to persuade a court or government investigator that missing records were not willfully destroyed. Courts generally do not look favorably on organizations that mismanage or dispose of records on an inconsistent basis, even if there was no bad faith motive in that inconsistency.

A good record retention policy will not only specify a record retention period for each type of relevant record (see chart at end of article for suggested, general purpose retention guidelines), but it will also establish a standard disposition policy. It may, for example, specify that the preferred method of disposition is shredding. A professional records management company or IT consultant can also assist you in managing and disposing of all records appropriately, including archived electronic files. As you develop your records disposal program, bear in mind that state and federal laws may dictate a certain type of records disposal process when certain information is included in a record. North Carolina law, for example, requires a written disposal procedure, certain diligence on records disposal vendors, and mandates a certain manner of disposal whenever "personal information" is included in your records. Finally, your record retention policy should identify a records custodian who is responsible for ensuring that the program is rigorously enforced from top management down.

The following chart provides some general records categories and suggested retention periods for commonly used records within the nursing home context and may serve as a good starting point for creating a record retention policy uniquely suited to your facility. Please remember, however, that many different sources of law may suggest specific record retention periods for specific types of records that may not be incorporated in this list. These retention periods are provided for informational purposes only and are not an adequate substitute for legal advice based on your individual business needs and legal requirements.

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Ken's Quote of the Month

"Half our life is spent trying to find something to do with the time we have rushed through life trying to save."

Will Rogers

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Toss or Keep... continued

TYPE OF RECORD	SUGGESTED RETENTION PERIOD
Clinical/Medical/Infection Control Records	5 years after discharge of an adult patient. If the patient is a minor when discharged, the facility shall ensure that the records are kept on file until his or her 19th birthday and then for an additional 5 years. If a facility discontinues operation, records must be stored in a business offering retrieval services for at least 11 years after the closure date.
HIPAA-Related Records	6 years from the date most recently in effect for HIPAA-mandated records such as policies or procedures, notices of privacy practices, consents, authorizations, and accountings of PHI disclosures
Governance (board minutes, bylaws, foundation documents)	Typically retained permanently
Quality Assurance, Safety Committee, and Abuse Investigation Records	Retain for 5 years
Finance/Accounting	Medicare specifies a retention requirement of 4 years; the recently revised Medicaid Provider Participation Agreements specify a minimum retention period of 6 years for all Medicaid finance and accounting records; it is common to retain these records for 7 years due to certain tax and financial reporting obligations at the federal level
Employment Application, Résumé, Hire/ Promotion/Demotion/Transfer Decision, Request for Accommodation, Evaluations, FMLA Records	4 years after date of termination/resignation
I-9 Immigration Forms	3 years after hiring or 1 year after termination, whichever is later
Wage Records (rates of pay, time earning sheets, etc.)	5 years after the calendar year in which compensation was paid
Most OSHA/Safety Records (including inspection/training records)	5 years following end of calendar year covered by the record (some specific types of OSHA records have much longer retention period, such as exposure records and employees' medical files)
Contracts with Vendors/Suppliers	For contracts valued at $10,000 or more over a 12-month period, Medicare regulations specify a retention period of 4 years after the service(s) is furnished under the contract or subcontract; state laws imposing statutes of limitation on contracts actions may be as long as 15 years, however
Tax Records	7 years after taxes at issue were due or paid, whichever is later
Compliance Records (committee minutes, reports to the board, internal audits, etc.)	Based on a survey AHCA performed in 2007, 10 years appears to be the most common retention period for these records

Editor's Note – Special thanks to Kristi Huff, JD, director of government relations for the N.C. Healthcare Facilities Association, for co-authoring this article with me.