Missouri Association of Nursing Home Administrators

February/March, 2016

2016 Annual Convention

Charting a New Course with MANHA

June 5-8, 2016

Camden on the Lake
Lake Ozark, MO

The Farm-to-Table Act Passes the House!

by Rebekah Lucas, Governmental Liaison Chair

MANHA has been a crucial part in the formation and passage of this bill. Farm-to-Table, aka Farm-to-School, is not a new idea. What is new is the inclusion of our senior population. This bill will allow farms that have been state inspected (required for any farm to sell meat, vegetables, bread, etc.) to sell to local institutions. Currently, long-term care communities can only purchase food from a federally inspected processing plant.

This bill (HB2244) was expanded to included institutions like ours in this state. Our seniors are begging us for farm fresh food. Now we are closer than ever to the goal of providing the quality farm fresh food our residents are starting to expect. This bill has yet to pass the Senate and be signed by our Governor, but we are well on our way.

This bill is a CHOICE, you certainly don't have to participate in the "Farm-to-Table" Act. Every community is different and this bill acknowledges that fact. These are the reasons this bill is so great. From an Administrator perspective, this bill allows me to address complaints received about food. We all get them. Instead of looking to food service staff for answers, we can now look to the products we have and take a deeper more complex look at our food service as a whole.

Missouri Legislative Session Update

The following are bills being watched by MANHA, as they pass through the legislature. These are only a few being monitored, as they have some activity. To access full text of bills and actions taken go to http://www.house.mo.gov or http://www.senate.mo.gov and then "Bill Information."

HB 1392

Changes the requirements for DHSS to survey every hospice to not less than every three years.

HB 1428

Revises the definition of "service dog" to include animals that provide support or therapeutic functions for individuals with psychiatric or mental disabilities.

HB 1462

Prohibits an employer from requiring a person to become a member of a labor organization as a condition or continuation of employment.

HB 1466

Establishes guidelines for the regulation of occupations and professions not regulated by the Division of Professional Registration.

HB 1565

Raises the Mo Healthnet asset limits for disabled persons.

HB 1607

Establishes licensure requirements for music therapists.

HB 1643

Makes CPR instruction a high school graduation requirement.

HB 1701

Prohibits an employer from requiring a person to become a member of a labor organization as a condition or continuation of employment.

HB 1715

Specifies that bullying an elderly person constitutes elder abuse.

HB 1763

Changes the laws regarding workers' compensation large deductible policies issued by an isurer.

HB 1789

Changes the laws regarding public administrators to require the county to provide a staff if the public administrator handles at least fifty cases.

HB 1855

Changes the laws regarding health care facility infection reporting.

HB 1870

Modifies provisions of the Big Government Get Off My Back Act and provides income tax deductions for small businesses.

HB 2107

Modifies provisions relating to the collateral source rule and provides that parties may introduce evidence of the cost, rather than the value, of the medical care or treatment rendered.

HB 2441

Specifies that certain health care facilities operated by the state are not exempt from certificate of need requirements.

"Legislative Update" >p3

Legislative Update *(from page 2)*

SB 619

Requires elder abuse investigators to provide specified written materials to alleged perpetrators.

SB 635

Establishes the Mo. Palliative Care and Quality of Life Interdisciplinary Council and the Palliative Care Consumer and Professional Information and Education Program.

SB 654 and **SB 776** and **SB 845**

Modify certificate of need requirements for long-term care facilities.

SB 670

Requires long-term care facilities to institute policies facilitating familial involvement in the well-being and support of its residents.

SB 700

Relating to workers' compensation premium rates.

SB 702

Modifies the law relating to unemployment compensation benefits.

SB 725

Modifies provisions of law relating to wages paid to employees.

SB 745

Modifies the law relating to unlawful discrimination.

SB 759

Creates a crime for employers who divulge certain personal information of employees and customers.

SB 826

Modifies provisions regarding professional nursing and collaborative practice arrangements.

SB 876

Modifies the law relating to discharge of employees under workers' compensation statutes.

SB 878

Changes the "Farm-to-School Act" and program to the "Farm-to-Table Act" and program.

SB 887

Establishes the Advance Health Care Directive Registry.

SB 951

Modifies provisions of the Missouri Preneed Funeral Contract Act

Training Sessions

Online Training Courses

Go to: www.mlnha.org
Click on Staff Development Solutions
Click on Staff Certifications
See Course Catalog on next page.

For futher information, contact Gayla at 573-634-5345, ext 2.

Some of the Online Training Courses

Administrator SNF State Study Course
ALF Assessor Training
RCAL State Study Course
RCAL National Study Course

CNA Training

MANHA Training Ctr.
5-Week Courses - On-Going

Activity Director Training

March 7 – 11, 2016
October 10-14, 2016

Social Service Designee

April 4-8, 2016 - MHCA Office, Jefferson City
October 3-7, 2016 - MHCA Office; Jefferson City

Preceptor and Preceptor Renewal Training

June 5, 2016 - Camden on the Lake; Lake Ozark
October 21, 2016 - MANHA Office; Jefferson City

A WINTERFEST THANK YOU!

MANHA would like to thank the many vendors who supported us at our Winterfest Conference & Trade Show.

Diamond Sponsor

Wilkinson Health Services

Platinum Sponsors

McKesson Medical Surgical
Rich & Cartmill Insurance
UVanta Pharmacy

Gold Sponsor

Senior Care Pharmacy

Silver Sponsors

Graves Menu Maker Foods
Rehabcare
Simplex Grinnell

Sponsors

Alixa RX
American Medical Technologies
Barnes Healthcare Management
Blue Strata E.H.R
Boyce & Bynum Pathology Laboratories
Carpenter & Company
Center for Patient Safety
Central States Bus Sales
Commerce Bank
Electronic Contracting
Ergo Midwest
Family Pharmacy
H2Only – Water Treatment
Health Direct
Health Services GPO

Sponsors *(Continued)*

Health Technologies
Heartland Health Laboratories
HMP DME Services
Invacare
Just Jewelry
Kenwood/WS Communications
Martin Bros Distributing
MASSCO
Mo. Division of Labor Standards
Mo. Nursing Home Insurance Trust
Medline
MMS-A Medical Supply Co
Mobilex USA
Outreach Eye Care
Partners Pharmacy
Preferred Podiatry Group
Premier RX Health Solutions
RJ Kool Company
Scrubs on Wheels
Select Rehabilitation
Senior Blue Book
Senior Dental Care
Service Master Recovery
Southern Bus & Mobility
Special Care Management
Specialized Wound Management
Springfield Foodservice
Staff Development Solutions
Sterling Dental
The ReThink Consortium
United Scripts

MANAGEMENT OF DIABETES IN LONG-TERM CARE AND SKILLED NURSING FACILITIES:

A POSITION STATEMENT OF THE AMERICAN DIABETES ASSOCIATION DIABETES CARE 2016

Diabetes is more common in older adults, has a high prevalence in long-term care (LTC) facilities, and is associated with significant disease burden and higher cost. The heterogeneity of this population with regard to comorbidities and overall health status is critical to establishing personalized goals and treatments for diabetes. The risk of hypoglycemia is the most important factor in determining glycemic goals due to the catastrophic consequences in this population. Simplified treatment regimens are preferred, and the sole use of sliding scale insulin (SSI) should be avoided.

This position statement provides a classification system for older adults in LTC settings, describes how diabetes goals and management should be tailored based on comorbidities, delineates key issues to consider when using glucose-lowering agents in this population, and provides recommendations on how to replace SSI in LTC facilities. As these patients transition from one setting to another or from one provider to another, their risk for adverse events increases. Strategies are presented to reduce these risks and ensure safe transitions. This article addresses diabetes management at end of life and in those receiving palliative and hospice care.

The integration of diabetes management into LTC facilities is important and requires an interprofessional team approach. To facilitate this approach, acceptance by administrative personnel is needed, as are protocols and possibly system changes. It is important for clinicians to understand the characteristics, challenges, and barriers related to the older population living in LTC facilities, as well as the proper functioning of the facilities themselves. Once these challenges are identified, individualized approaches can be designed to improve diabetes management while lowering the risk of hypoglycemia and ultimately improving quality of life.

GENERAL APPROACH TO CARE

RECOMMENDS

Management of diabetes among older adults residing in LTC facilities is challenging due to heterogeneity in this population. Careful evaluation of comorbidities and overall health is needed before developing goals and treatment strategies for diabetes management. Diabetes management in LTC patients (residents) requires different approaches because of unique challenges faced by this population and the workings of LTC facilities.

NEED FOR DIFFERENT APPROACHES FOR LTC POPULATION

The challenge of caring for older adults with diabetes arises not only from their clinical heterogeneity but also from their considerable variability in living arrangements and social support, which significantly impacts diabetes management. Some older adults live independently, some in assisted care facilities that provide partial support with medical management, and some in fully supervised LTC facilities. As the challenges and self-care responsibilities change in these different environments, different recommendations are needed for each setting on how to manage diabetes in individual patients and protocols to LTC staff who may be operating without the presence of a practitioner for prolonged periods.

The most extensive guideline available was developed by the American Medical Directors Association (AMDA). These guidelines include a 12-step program for LTC staff that comprises all phases of diabetes care from diabetes detection to institutional quality assessment. The glucose-lowering steps advocated by the AMDA are

“Diabetes Management” >p6

DIABETES MANAGEMENT *(from page 5)*

consistent with those published in the ADA position statement on patient-centered, individualized approaches to glucose lowering in adults with diabetes.

To achieve goals, it is acknowledged that the notion of a "diabetic diet" is outdated and that a more liberal diet may be appropriate among LTC patients. The guidelines are fairly nonspecific with regard to choice of glucose-lowering agents but advise practitioners to avoid the use of SSI and to transition to scheduled basal insulin (and prandial as required) shortly after admission.

Beyond these long-term goals of care, the AMDA guidelines provide recommendations to LTC staff regarding when to call a practitioner. The guidelines recommend that LTC facilities develop their own facility-specific policies and procedures for hypoglycemia treatment. These guidelines emphasize that frail patients with cognitive impairment may present with atypical symptoms, mainly neuroglycopenic or behavioral in nature. The unique needs of patients with diabetes who are terminally ill or have limited life expectancy are also discussed.

DIABETES MANAGEMENT DURING TRANSITIONS OF CARE

Recommendations of care transitions are important times to revisit diabetes management targets, perform medication reconciliation, provide patient and caregiver education, reevaluate the patient's ability to perform diabetes self-care behaviors, and have close communication between transferring and receiving care teams to ensure patient safety and reduce readmission rates.

New Housing Construction Cools, Memory Care Still Hot

New construction plans have cooled slightly compared to last year, but memory care construction and repositioning are still booming, according to the 2015 *Seniors Housing and Care Survey* published by Lancaster Pollard. Although 51 percent of survey respondents indicated they would pursue a new construction project in 2016, it represents a 13 percent drop since last year.

Among respondents, more than half said they planned to change their service mix in the next 12 months to reposition themselves in the market. Nearly 70 percent said they were extremely likely or somewhat likely to take on a renovation project in 2016. Many organizations (53 percent) say they plan to pursue an acquisition.

Expectations for 2016 include plenty of growth and project activity in assisted living, especially housing related to memory care. Skilled nursing and continuing care retirement communities are expected to see the least growth, according to survey respondents. The number of seniors housing site participating in an accountable care organization (ACO) has risen dramatically in the past year. Now, 25 percent of those surveyed are part of an ACO, compared to just 9 percent in 2014.

The data on occupancy rates is also encouraging. While some responding organizations are struggling with censuses in the 70th and 80th percentile, the majority maintain rates of 90 percent or higher, with nearly 16 percent reporting occupancy rates of 95 percent.

Welcome to Our New MANHA Members!

BORDER STATES

Scott Cole
General Baptist Health Care

REGION 1

Melissa Miller

REGION 6

Clara Cannell
Fulton Manor Care Center

Tina Johnson
Ashley Manor Care Center

https://www.flickr.com/photos/mattdarbs/14819716835/

How the Top 2% Think. Literally.

The Success Habit I Wish I Knew 18 Years Ago.

by Tucker Graves, Health Services GPO

Most people live in a reactive state. They work on stuff until someone distracts them. Then they react to what the other person needs. That's true at home and in the office. And it's the easiest way to keep spinning your wheels for months or even years on end.

Look at the calendar of most people and you'll find a good assortment of the usual events like team meetings, one-on-ones, lunches, etc. You might also find some personal events scheduled, such as family dinners, soccer games, birthdays, etc.

But what won't you find on 98% of calendars?

Time blocked out to just think. Blocks of 1, 2 or even 3 hours at a time with no agenda. No additional attendees. No anything. Just "thinking time."

Time is our most precious resource. And where you spend your time influences how you do in every area of your life. Want a better body? Spend more time eating right. Want to be a better husband/wife? Spend more time listening. You get the idea.

But how do you know if you're working on the right things? You guessed it, you need to constantly re-visit your goals and strategy. Sometimes it makes sense to do that with people (colleagues, board, partner, family), but you also need some alone time where you can just lay your cards out on the table and think about what's working and what's not.

So what should you "think about" during the time you schedule to think? Here are some ideas:

- How are my important relationships going?
- Which goals aren't I making progress on? Why?
- What's coming up that I need to prepare for?
- What should I do differently?
- What new skill do I need to start learning? Why?
- Am I happy? If not, why not?
- How can I get more done this week?
- Should I take some time off?
- Am I working hard enough?

I'm sure you spend time thinking about these things, but I'd bet it's done in chunks of 10 or 20 minutes here and there, not 1 or 2 hours of solid, sit-in-a-quiet-place thinking that happens week in, week out.

As I was preparing to launch my previous company, I scheduled 5 hours each week just to think. During that time I was unavailable and literally unreachable to the outside world. I turned off my phone, closed my email, set my Mac to Do Not Disturb and put a note on my door "Do not disturb until 2pm."

During my thinking time I focus on not "doing" anything. I don't try to make progress on anything tangible. I don't mark off goals on a ToDo list. I just sit in silence and think about things that are important or top of mind.

I learned about this "success habit" from a life coach I had back in 2011 and it's a common strategy used by everyone from Beyonce to Bill Clinton, Roger Federer, Richard Branson and Tony Robbins.

How much thinking time do you need each week and which day is the best for thinking? Those answers will vary based on how you work, but for me it was Monday morning from 8am until 11am and Friday afternoons from 4pm to 6pm. I simply created two recurring events in my calendar each week at those times with the label "Thinking Time." It's such a simple way to do it, but if you stick with it, it will transform your life. Give it a try and you won't be disappointed.