NATIONAL ASSOCIATION OF LONG TERM HOSPITALS
NALTH

NALTH News

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PRESIDENT'S MESSAGE

I am very honored to have been elected to serve as the NALTH President for 2010 through 2012. To share a little information about myself, I was elected to the Board of Directors in 1997 and have consistently served the Association in various capacities. I have enjoyed actively participating with numerous committees and task forces, as well as being very involved with Legislators on behalf of NALTH, LTCH's in Michigan, and Bay Special Care Hospital (BSCH). Our hospital, which joined NALTH in 1995, has proudly supported the association for 15 years. I was hired by BSCH as its first employee and Director in 1994 and was promoted to President the next year. BSCH is a not-for-profit LTCH in East Central Michigan affiliated with Bay Regional Medical Center and McLaren Health Care Corporation. It is considered a "grandfathered hospital within a hospital" since it is located in an off-campus facility where the host hospital has an inpatient rehabilitation unit. Moreover, I am married with two grown children, their spouses and two grandchildren.

About the NALTH Board of Directors: The Board of Directors is the governing body and is responsible for strategically directing the Association by setting policy goals and strategies for the future. The three basic functions of the Board are to approve outcomes to be accomplished; to ensure the resources that are necessary for achievement are available and used efficiently; and to make sure the desired outcomes are being achieved. The Board consists of up to sixteen members, including one President, a maximum of two Vice Presidents, one Treasurer, a Secretary from the state of Massachusetts, and up to twelve other members.

Our Board is comprised of experienced executive leaders – mostly CEOs and CFOs from our industry. They are decision makers with the authority to vote and make decisions on behalf of the membership. Fundamentally, board members are very familiar with the LTCH industry, are committed to member interests, and seek input and clarification from the membership routinely. All board members come from dues-paying facilities that are NALTH members in good standing. The NALTH Board represents various geographic locations throughout the U.S.; with consideration given to representatives from all types of facility sizes, investor owned and not-for-profits, chain organizations, satellites, urban and rural, freestanding and hospitals within hospitals. All board members adhere to the highest ethical standards as defined by NALTH policy. Confidentiality is imperative as a board member. Significant volunteer hours are provided by each board member through attendance at routine calls, face to face meetings (travel to meetings is the responsibility of the NALTH member hospital), and committee and taskforce work. The investment is personal and significant. Please welcome the new NALTH Board of Directors elected by the membership during the NALTH Annual Meeting held April 29 and 30, 2010 in Washington D.C. (See listing in this newsletter).

Consistently, this organization has proactively worked with federal and state Legislators, CMS leaders and consultants to provide research-based proposals that are measurable and support our goals for quality care for our patients. Our future is influx as we monitor and attempt to predict future health care reform and reimbursement issues. Our goals will be to remain productive with our research and studies, advance in further development of our NHIS Database for quality patient outcomes, measurement and benchmarking, and monitor our members needs so that we can represent our members positively with CMS and Congress. We will continue to remain as unified as possible with the other LTCH organizations for a consistent message on behalf of the LTCH industry. It is our quality of patient care that is our focus as we represent our benchmarks to demonstrate the basis of what we do and why we do it.

We strive to improve communication with our membership through this (recently launched) newsletter, updates on our website: www.nalth.org, general membership calls, and educational opportunities at our meetings and courses. We continue to offer coder training as a consultation service and we provide timely responses to our membership by having a trained and resourceful management company and Administrative Director, Ryan Dryden.

On behalf of the entire Board, please keep us informed of your issues and concerns, and join us at our meetings so that you can utilize your membership and keep connected to our organization. I look forward to representing you. Please do not hesitate to contact me if I can be of service.

Respectfully Yours,

Cheryl A. Burzynski

Cheryl A. Burzynski, MSN, RN, NE-BC
NALTH President

THIS ISSUE...

President's Message 1
Member Spotlight 2
Member Research & Innovation 3
Health Reform Policy & Regulatory Update 5
NHIS Update 7
NHIS Feature Article 8
Leadership 11

NALTH encourages the submission of articles for publication. For more information, please contact

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NALTH CALENDAR

October 20, 2010
NALTH Board Retreat
(Board Members Only)

October 21-22, 2010
NALTH Education Conference
Multidisciplinary Frontiers in Treating the Long Term Care Hospital (LTCH) Patient
Treasure Island Hotel, Las Vegas, NV

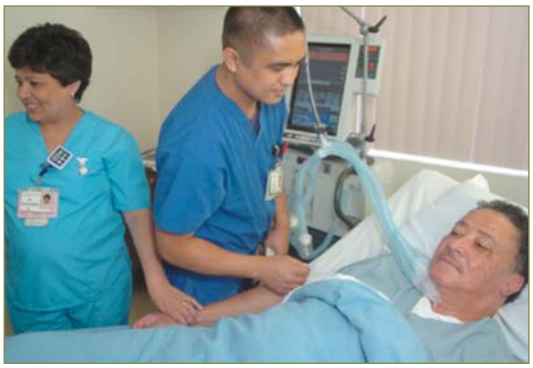
April 27, 2011
NALTH Board Retreat
(Board Members Only)

April 28-29, 2011
NALTH 2011 Annual Meeting
Omni Shoreham Hotel,
Washington, DC

Barlow Respiratory Hospital

Focused on *helping patients breathe easier*, Barlow Respiratory Hospital (BRH) proudly enters its 107th year of service to the Southern California community. Barlow Respiratory Hospital is a private, not-for-profit, 105 bed, long term care hospital (LTCH) with a wide-ranging and distinguished history of providing respiratory and medical care services to greater Los Angeles and the surrounding Southern California region. Founder Walter Jarvis Barlow, M.D., came west at the turn of the last century in search of a cure for his own case of "consumption." Through his efforts and the support of his patients, Barlow Sanatorium was established in 1902 Elysian Park, Los Angeles, to treat those stricken with tuberculosis. In 2002, residing on the original campus, we celebrated our centennial anniversary.

The hospital, located in a 26-acre urban park setting next to Dodger Stadium, is internationally recognized for its expertise in weaning patients from prolonged mechanical ventilation (PMV) in the post-ICU setting. Well-known as a *Regional Weaning Center*, BRH admits over 300 ventilator-dependent patients each year, transferred from the ICUs of over 50 area hospitals, for weaning from prolonged mechanical ventilation (PMV). Over the last two decades, our Ventilator Weaning Program has consistently produced weaning success rates of nearly 60% of patients weaned from mechanical ventilation at time of discharge. These successful weaning outcomes, along with the results of other studies in this population, have resulted in numerous publications in peer-reviewed medical journals, establishing Barlow Respiratory Hospital as the benchmark for weaning from prolonged mechanical ventilation.



Under the direction of Margaret W. Crane, President and CEO, and David R. Nelson, M.D., Medical Director, Barlow has long been established as an important regional resource for the diagnosis and treatment of chronic lung disorders, and lung and respiratory diseases. Our staff is dedicated to providing superb, expert clinical care for patients with COPD, emphysema, asthma, chronic bronchitis, pulmonary fibrosis, and other chronic breathing disorders. With the main hospital, two strategically placed satellites and a multispecialty medical staff, Barlow Respiratory Hospital is equipped to treat more than 1,000 adult patients a year.

We take an interdisciplinary team approach to care in each of our specialized programs – Ventilator Weaning, Pulmonary Rehabilitation, Chronically Critically Ill Care, Wound Care and Palliative Care – treating a full range of complex medical conditions. Barlow physicians and patients benefit from a wide spectrum of available pulmonary and critical care diagnostic services, interventions, treatments and therapies. Patients suffering from delirium secondary to a prolonged ICU stay resulting from the effects of critical illness, medications, and disrupted sleep/wake patterns benefit from our new Sensory Stimulation Program. Realized through a substantial grant award, the purpose of sensory stimulation activities for selected patients is to enrich their environment, counteract the adverse effects of sensory deprivation and accelerate the recovery process. Offered to all, evening support groups are facilitated by our MSW team from the Department of Social Services. The support groups provide encouragement, guidance and assistance for families of our patients with prolonged severe illness.

At Barlow, all patient-related data – clinical, financial, administrative and communication – is in a single confidential electronic health record (EHR) of care. The MEDITECH Health Care Information System at Barlow serves to improve operations, better coordinate care, prevent medical errors, streamline workflows, hasten reimbursements and operate more efficiently. Our most recent module implementation is Computerized Provider Order Entry (CPOE). Barlow is one of the first LTCH hospitals to implement CPOE, an important solution to the challenge of reducing medical errors, and improving health care quality and efficiency.

Service to the Community

Barlow Respiratory Hospital serves the greater Los Angeles area through education and outreach activities for numerous local organizations, agencies and schools. Each year, Barlow hosts two continuing medical education conferences for the pulmonary/critical care community. The *Sam J. Sills, M.D. Distinguished Scholar Program*, held on our campus each spring, is presented with Breathe California of Los Angeles County, in collaboration with the Trudeau Society of Los Angeles. In the fall, Barlow sponsors the *Hans E. Einstein, M.D. Lectureship* as part of our Annual Meeting of the medical staff. The lectureship, now in its 10th year, honors Hans E. Einstein, M.D., a former Barlow Medical Director and CEO, and current member of the Board of Directors. Dr. Einstein is a local legend and internationally recognized expert in acute coccidioidomycosis, more commonly known as Valley Fever. Both lecture series draw nearly 80 physicians, nurses and respiratory care practitioners from surrounding academic medical centers and community hospitals for an evening of networking and science.

Barlow also serves as a teaching hospital for students from the Keck School of Medicine of the University of Southern California, and the UCLA David Geffen School of Medicine. In addition, the hospital hosts allied health professional school programs through affiliations with universities, community colleges and vocational training centers. Barlow is the proud home to the Lung Rangers, a support group for pulmonary patients open to all of our alumni as well as the community at large. Patients currently enrolled in our Pulmonary Rehabilitation Programs are also encouraged to attend the bimonthly luncheon presentations.

Barlow Respiratory Research Center

For two decades, Barlow Respiratory Research Center (BRRC) has been committed to excellence in clinical research, addressing issues related to chronic lung diseases and weaning patients from prolonged mechanical ventilation. Research is focused on studying the patient populations treated in the many programs at Barlow Respiratory Hospital (BRH). Our health services research and outcomes studies seek to identify the most effective and efficient interventions, treatments and services often referred to as "best practices." Research grants have funded studies in the areas of weaning, pulmonary physiology, protocol development, and end-of-life and palliative care. These efforts have resulted in the publication of four book chapters, 15 papers in peer-reviewed medical journals, nearly 50 abstracts, and numerous editorials and communications.

Barlow Respiratory Hospital *...continued from page 2*

Administered by Meg Hassenpflug, MS, RD, FCCM, the Research Center maintains the Ventilation Outcomes Database (VOD), the largest single facility database capturing outcomes of weaning from prolonged mechanical ventilation in the post-ICU setting of a LTCH. Now with nearly 4,000 patients' data – pre-admission, admission, outcome, discharge, functional status, and survival data – the VOD is the foundation for all clinical studies of ventilator-dependent patients admitted to Barlow Respiratory Hospital for weaning. The VOD served as the template for the study: *Post-ICU Mechanical Ventilation at Long Term Care Hospitals: A Multicenter Outcomes Study*, a 23 facility study of weaning outcomes sponsored by NALTH. Led by BRRC staff members, the results of the study were published as two papers in the January 2007 issue of the peer-reviewed cardiopulmonary journal *CHEST*. For additional study information and a list of participating facilities, please visit: http://www.barlowhospital.org/ventilatoroutcomes/.

Our research efforts are enhanced by academic partnerships with the Keck School of Medicine of the University of Southern California, UCLA David Geffen School of Medicine, VA Greater Los Angeles Healthcare System and the Institute for International Health, University of Sydney, Sydney, Australia. Together, BRH and BRRC have earned national and international recognition in the areas of post-ICU mechanical ventilation and outcomes research on weaning patients from prolonged mechanical ventilation.

New Hospital Building

Barlow Respiratory Hospital is building a new state-of-the-art medical facility and wellness campus while incorporating amenities to benefit the surrounding community. The campus will include the new hospital, as well as greatly needed community housing and facilities for recreation, education and wellness. Key historic buildings will be preserved, restored and reused as community meeting centers and gathering places. Making use of the existing site will enable us to maintain our historic presence in the Elysian Park area of Los Angeles, valued by patients, families, employees and staff alike. Preserving the lush environment, the wellness campus will feature walking paths, trails and plazas to maintain the park-like feel of the neighborhood. Mature trees will be preserved and well-designed landscaping improvements will strengthen the visual appeal of the boulevard.

Now surpassing more than a century, Barlow's remarkable history makes it one of the most unique and important healthcare facilities in Southern California. Today, Barlow is recognized as one of the nation's leading centers for weaning patients from prolonged mechanical ventilation, treatment of pulmonary diseases and caring for patients with complex medical conditions. Barlow serves as a resource within the healthcare community and the community-at-large by adhering to standards of excellence in patient care, research and education, fulfilling our mission to improve the quality of life for patients with respiratory and other related diseases that may require prolonged acute hospitalization or specialized treatment in the Southern California region.

Website: **www.barlowhospital.org**

Each NALTH newsletter will highlight a member hospital's outstanding program or community benefit. Please contact NALTH to suggest a member to spotlight.

Goldberg Innovation Award

The Award

The Goldberg Innovation Award is given in recognition of an innovative process or technology that supports long term care hospitals (LTCHs) and is usually presented in conjunction with the NALTH Annual Meeting. All employees and professional staff associated with NALTH member facilities in good standing are eligible to submit entries. The overarching principle in the review process is innovation. Please see the current Call for Submissions for details.

2010 Goldberg Innovation Award Recipient

Holy Family Medical Center
Des Plaines, Illinois

Reducing Long Term Care Hospital (LTCH)
Central Line Associated Bloodstream Infection (CLABSI) Episodes

Marti Edwards, Mark Palmer, Mary Jane Cullinan, Kathy Hollich, Shelami Cunanan
and the entire Plan-Do-Study-Act (PDSA) CLABSI Team

Introduction

Our 105 bed Long Term Acute Care (LTACH) Hospital, ranks in the top five percent acuity among all LTACHs nationwide based on publically available data on Medicare's case mix index. Over seventy-five percent of our LTACH's patient population requires central line catheters.

Infection control surveillance identified a CLABSI rate of 2.8 (from July 2008-June 2009) above the National Healthcare Safety Network (NHSN) benchmark for medical ICUs of 2.4 per 1000 central line catheter days. Central line associated blood stream infections (CLABSI) are a common complication of central line catheters. In 2009, our LTACH had 49 episodes of CLABSI(s). A large percent of the patients admitted are colonized with multi-drug resistant organisms (MDRO). The cost per episode was valued at approximately $10,000 per case in additional pharmacy costs and related medical interventions (14 charts reviewed, average $10K per case).

...continued on page 4

Goldberg Award...*continued from page 3*

Innovation Abstract

A PDSA (Plan-Do-Study-Act) multi-disciplinary team was formed to analyze the process and find the root cause(s) of the high CLABSI rate. The team adopted a new and unique paradigm from acute care evidence, implementing a pilot study on a North unit, using a 2% chlorhexidine bathing product. On this unit, the CLABSI rate was reduced by 47% in the three-month pilot study, and the overall LTACH CLABSI incidents were reduced by 35%. The overall reduction in CLABSI incidents are used herein to meet the objectives of the Goldberg Award.

Team objective

Reduce the CLABSI rate in a cost-effective manner.

Method

Using the PDSA process improvement method, the team analyzed the cleaning practice of central line catheters and patients, and developed solutions to solve the root causes of each identified practice variation. North unit was chosen as the beta site for this analysis.

The PDSA team identified:

- Staff and product variations in patient bathing.
- Traditional soap and water bathing practice does not fully sanitize the patient's skin, and has a limited effect on the bacterial skin burden.
- The North unit had an individual CLABSI rate of 5.1 incidents per 1,000 patient days from July 2008 - June 2009.

A recent article published by the Joint Commission, "Inside Joint Commission," February 1, 2010, has shown that a SICU in a North Carolina trauma center has significantly reduced their CLABSI rate using 2% chlorhexidine gluconate impregnated bathing cloths. Another article from Clinical Infectious Diseases references a supporting claim.

Solution to root cause: "Bath-by-Numbers"

A four-month infection control intervention entitled by the team as "Bath-by-Numbers" was implemented in October of 2009. The 2% chlorhexidine pre-packaged bath wipes and warmers for the trial period were provided. The product is packaged with six bathing wipes designated for use in a particular order to bathe a patient in a precise method.

The step-by-step bathing method associated with the chlorhexidine bath wipe eliminates nursing bathing technique variation, sanitizing the patient's skin with less labor (less time). The patient's skin remains sanitized for 24 hours, reducing potential contamination of the central line apparatus, the root cause of the PDSA team's objective.

In partnership with the supplier, this LTCH also created a training video depicting the repeatable, step-by-step, Bath-by-Numbers technique. A physician from the Division of Infectious Diseases at an unaffiliated county hospital volunteered to demonstrate the product for the video. All shifts of the North unit were in-serviced by nursing education using the video.

Measurement

The "Bath-by-Numbers" pilot study measures were:

- Statistical Process Control Chart (SPC) of pre/post pilot CLABSI rate for the North unit
- SPC chart of pre/post pilot CLABSI incidents for this LTACH
- Staff product evaluation
- Financial analysis: Labor savings and lost revenue

Uniqueness

The creation of the "Bath-by-Numbers" method is unique to LTCH's because much of the published evidence exists only for acute care hospitals, where the main benefit of reducing the CLABSI incidents is a reduction in the patient's extended Length of Stay (LOS), due to acquiring the infection.

Pilot study implementation results

The results were compared in the pre- and post-pilot intervention time periods:

- 47% decrease in the monthly CLABSI rate (4.3 down to 2.37) on the North unit.
- 35% decrease in the monthly CLABSI episodes (4.6 down to 3) of this LTACH.
- 29% decrease in bathing labor time (35 min. down to 25 min. per patient).
- $5.00 per-patient bathing cost increase (basin-soap method cost miniscule).

The pilot study's effect on the entire LTACH was a 35% reduction in the number of CLABSI episodes. The LTACH patients experienced a total of 49 CLABSI episodes from July 2008 – June 2009.

Current government reimbursement policies have historically covered these costs.

Future indications of CLABSI episodes are considered hospital acquired conditions by CMS and will no longer be reimbursable. Below we looked at two scenarios: future and current financial reimbursement.

Financial impact using future reimbursement

Medical intervention cost reduction (future reimbursement)

49 episodes/yr x 35% reduction x $10,000 additional costs = $171,500

Labor cost reduction (future and current reimbursement)

The Bath-by-Numbers can eliminate two positions with house-wide implementation and one with central line patient implementation as follows:

31,000 patient days x 1 bath/day x 10 min/bath x 1hour/60 min = 5,166 labor hours

5,166 Hours/2,080 hours per Patient Care Technician (PCT) at $20/hour = $83,200

This becomes $41,600 if used on only central line patients which represent 57% of patient days.

Material cost increase (for both future and current reimbursement)

31,000 patient days x 1 bath/day x $5.00/bath = $155,000

17,750 central line patient days x 1 bath/day x $5.00 bath=$88,750

...*continued on page 6*

Current Policy Changes and Issues

By Edward D. Kalman
NALTH, General Counsel
Behar & Kalman, LLP
Boston, MA

The NALTH 2010 annual meeting provided attendees with information which is important to both long and short term planning in several important areas:

1. CMS' contract with Wisconsin Physician Services (WPS) to conduct medical necessity reviews of LTCHs expires in June of 2011. CMS has not decided whether to renew this contract. NALTH notes that WPS is contracted to perform "expanded medical necessity review" under Section 114 of MMSEA of 2007. MMSEA of 2007 also provided funding for medical necessity review for a, limited, three year period. The two year extension of MMSEA LTCH relief provisions which was enacted as part of the Patient Protection and Affordable Act of 2009 omits this provision and consequently does not contain any additional funding for medical necessity review. Accordingly, there is a possibility that WPS' contract will not be renewed.
2. CMS advised the NALTH membership that the long awaited report to Congress on the feasibility of establishing patient selection criteria for LTCHs would be issues shortly. While we have heard this in the past we have now been informed that the report will not contain any LTCH patient selection criteria.
3. NALTH discussed with the membership that it is in the process of communicating with policy makers on significant questions related to implementation of policy changes evolving from health reform. One such issue is how bundled payments may affect the benefit package which is available to Medicare benificiaries and the liability of Medicare secondary payors. Bundled payments, including payment for post acute care services are to be made under a national bundled payment pilot, as part of a continuing care hospital pilot and by new Accountable Care Organizations. NALTH has recently issued a policy statement on this issue which is reproduced in the next column.

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POLICY STATEMENT

Medicare Health Reform
Bundled Payment Medicare Benefit Issues
Revised as of May 20, 2010

Potential Distortion of Medicare Benefits

- The Patient Protection and Affordable Act of 2009 mandates a number of pilot programs to test payment for Medicare services through "bundled" or global payments to health care providers. A national pilot program on payment bundling is scheduled to commence not later than January 1, 2013. Bundled payments cover all Part A and Part B Medicare benefits, including post-acute care services. This statement raises a number of questions concerning the manner in which bundled payment arrangements, which include payment for post acute care, may operate to change the level of Medicare benefits available to program beneficiaries. As a related matter, bundled payments may affect beneficiary co-insurance and deductible obligations, patient spend-down as well as Medigap, Medicaid and other secondary Medicare payor obligations. The current Medicare benefit package provides beneficiaries with a Medicare Part A hospital benefit of up to 150 days of which days 1-60 are fully covered except for $1,100 and days 61-90 are covered except for $275/day. Sixty reserved days, which may be used only once (days 91-150), are covered except for $550/day. The Medicare Part A SNF benefit period spans 100 days for a spell of illness that typically commences after a 3-day hospital stay. The first 20 days are covered in full; during the next 80 days, a beneficiary is required to pay $137.50/day. Under the Medicare benefit package the accrual of Medicare benefit days and related beneficiary co-insurance and deductible obligations are closely aligned to traditional fee for service payment systems and type of provider e.g. hospital or skilled nursing facility (SNF) in which a beneficiary receives covered services.

...continued on page 9

Goldberg Innovation Award ...continued from page 4

Training cost will be negligible with the online Bath-by-Numbers video instruction.

Net gain (loss) using future reimbursement

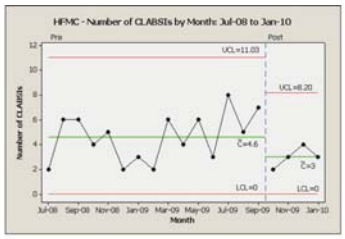
$171,500 + 83,200 - $155,000 = $99,700 if used on all patients

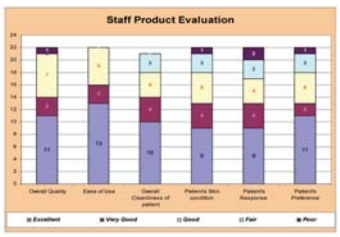
$171,500 + 41,600 - $88,750 = $124,350 if used on all central line patients (17,750 central line days)

Financial impact using current reimbursement

Medical intervention cost reduction (using current reimbursement)

Since costs are currently reimbursed, there is not a cost reduction. However, the reimbursement impact is as follows. Our study revealed that if we replaced the CLABSI patients with new admissions, our reimbursement would increase by $105/day. This would equate to $28,350 improved reimbursement using a 35% infection reduction rate.





Net gain (loss) using current reimbursement

$83,200 + $28,350 - $155,000 or ($43,450) loss if used on all patients

$41,600 + $28,350 - $88,750 or ($18,800) loss if used on central line patients (17,750 central line days)

Lessons learned

Implementing the "Bath-by-Numbers" method using 2% chlorhexidine impregnated bathing wipes throughout this LTACH is expected to decrease future CLABSI episodes to near zero levels, further improving the financial impact, beyond what has been documented herein.

A positive ROI is a good outcome; however, just as important is decreased patient suffering due to these results. With mandatory reporting, fewer CLABSI's will have an even stronger impact on the bottom line.

Patient acceptance of the bath wipe was between 80% - 99%. Variations were noted and can be found in the PDSA attachment. Employees were also pleased with the performance of the product and rated it good-to-excellent.

References

Holder, C., Zellinger, M. (2009). Daily Bathing with Chlorhexidine in the ICU to Prevent Central Line-Associated Bloodstream Infections. The Journal of Clinical Outcomes Management, 16(11).

Munoz-Price, MD, L.S., et al. (2009). Prevention of Bloodstream Infections by Use of Daily Chlorhexidine Baths for Patients at a Long Term Acute Care Hospital. Infection Control and Hospital Epidemiology, 30(11), 1031-1035.

Munoz-Price, L.S. (2009). Long-term Acute Care Hospitals. Healthcare Epidemiology, 49, 438-443.

Paper with supporting attachments available at www.nalth.org\2010goldberg.pdf

Do you have questions or want more information? Please contact Marti Edwards, VP of Patient Care Services, Holy Family Medical Center at medwards@reshealthcare.org

News from NALTH's Benchmarking System

National Data Updated: The Lewin Group has been busy adding National Medicare data to NHIS. You can now see publicly available data on ***392 LTCHs nationally*** in NHIS reports for the period October 2007 (Q4) - September 2008 (Q3). National Medicare data can be seen in the following reports:

- NHIS Operations Report - including cost per day by ancillary service, payor mix, charges, FTEs per occupied bed, key financial ratios and other valuable information.
- DRG Detail Reports – discharges and length of stay by MS-LTC-DRG, case mix index, discharge disposition, cost per discharge, Medicare cost and revenue per case and per day, etc.

Executive Summary Report: Programming is underway for the NHIS Executive Summary Report and the on-line report is coming soon! The Lewin group expects to launch the report on NHIS in June. This new report will be a helpful summary of key quality, financial and operations indicators in an easy-to-read summary format suitable for management and Board reporting. More information will follow soon.

Outcomes Report: Looking to share your patient outcomes with your referral sources? Please see the new "Patient Outcomes Report" template located in the "Resource Section of NHIS". This report was approved by NALTH in 2009 and is now available for participant use.

NHIS: An Innovative Performance Benchmarking System for LTCHs

The NALTH Health Information System (NHIS) was designed specifically for long term care hospitals (LTCHs) and provides reports on **quality, patient outcomes, operational performance and financial performance*, all in one system*.**

"When NALTH developed this system, CMS had just launched the prospective payment system for LTCHs and was raising questions about the role and the value of LTCHs in the healthcare system. NALTH was looking to develop a system that would be helpful for hospitals and would help to answer CMS' questions in a timely and patient-centered manner" says Margaret Crane, C.E.O. of Barlow Respiratory Hospital and a member of NALTH's Board of Directors. "We also saw how CMS was beginning to address pay-for-performance in other sectors and wanted an LTCH-driven forum to shape future measures for LTCHs." And now that CMS will require Quality Reporting for LTCHs in 2012, NHIS is well positioned to serve as a valuable resource to policy makers. MedPAC leaders have seen the system and are very impressed with the capabilities

After an extensive planning effort with significant input from interested hospitals, NALTH launched NHIS in 2006. NHIS' web-based system was developed by and is operated for NALTH by The Lewin Group, Inc. ("Lewin") and information systems consultants from RDA Corporation ("RDA"). NALTH has sought to assure accurate reporting, statistically valid conclusions and security of hospital and patient identity and has great confidence in Lewin's oversight. NALTH also has engaged Susan Glasser of Benchmark HealthCare Consultants ("Benchmark"), an experienced LTCH clinician and administrator, to serve as NALTH's NHIS Contract Manager, whose job is to make sure that NHIS Subscribers' needs are met. NALTH's relationship with Lewin, RDA and Benchmark, entities which understand LTCHs and the LTCH industry, has contributed greatly to the success of NHIS.

The system is **open to all LTCHs nationwide**. "Imagine the clinical value of a large, industry-wide data repository" says John Votto, D.O., President and C.E.O. of The Hospital for Special Care and former President of NALTH. "It can make a huge contribution to LTCH care delivery and provide a very strong foundation for communications with CMS. We think adopting a common data repository is very strategic and will provide much more useful information than smaller groups of hospitals working with various vendors, using different measures and different definitions."

Focus on Quality and Outcomes

NHIS is approved by The Joint Commission as a Non-Core Oryx vendor and offers 22 different ORYX indicators. The NHIS Quality Committee, consisting of clinicians from participating hospitals, is charged with overseeing the development of quality indicators and assuring rigorous data definitions to assure meaningful information is provided by, and available to, NHIS Subscribers. The initial list of indicators was developed based upon a survey of what was most meaningful to participating hospitals. NHIS indicators have evolved over time and will continue to change in the future, in response to Subscriber input and CMS initiatives. The NHIS Quality Committee has been careful to build a strong evidence base for each indicator, based upon extensive information available from NQF, AHRQ, The Joint Commission, IHI, CDC, NDNQI and other expert sources. The NHIS Quality Committee and Contract Manager update the evidence-based references and add, delete or modify indicators during an annual review process. NALTH designed the system to be flexible and to evolve over time to continually meet NHIS Subscribers' needs. NALTH also is considering submission of the NHIS indicators for approval by the National Quality Forum.

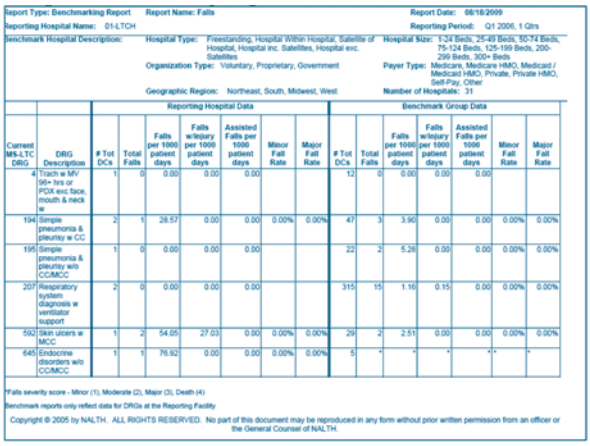
Current Quality and Outcomes Indicators Include:

- Ventilator Patient Outcomes
- Device-Related Infection Rates (VAP, CLBSI, CAUTI)
- Pressure Ulcer healing rate
- Adverse Events (LTCH-acquired pressure ulcers, fall rate, falls with injury, VTE rate)
- Discharge Disposition
- Functional Improvement

Helpful DRG Detail

Typical of many reporting systems, NHIS Subscribers obtain results for all patients discharged in a given time period. With NHIS, they also can drill down to the MS-LTC-DRG level to see results. Hospitals have been able to look at indicators such as fall rates among different patient types and confirm that certain patients are indeed at higher risk. The MS-LTC-DRG-specifics help NHIS Subscribers to understand how their hospital's case mix is similar to or different from other LTCHs and can provide a helpful focus for quality and management improvement initiatives.

Sample Benchmarking Report: Patient Falls

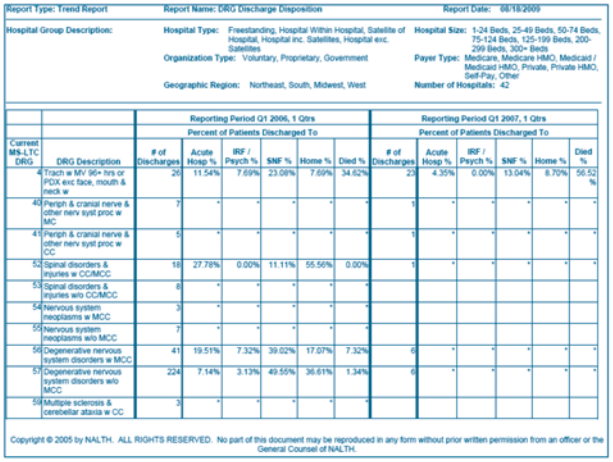


Report Type: Benchmarking Report — Report Name: Falls — Report Date: 08/18/2009
Reporting Hospital Name: 01-LTCH — Reporting Period: Q1 2006, 1 Qtrs
Benchmark Hospital Description: Hospital Type: Freestanding, Hospital Within Hospital, Satellite of Hospital, Hospital inc. Satellites, Hospital exc. Satellites; Organization Type: Voluntary, Proprietary, Government; Geographic Region: Northeast, South, Midwest, West; Hospital Size: 1-24 Beds, 25-49 Beds, 50-74 Beds, 75-124 Beds, 125-199 Beds, 200-299 Beds, 300+ Beds; Payer Type: Medicare, Medicare HMO, Medicaid / Medicaid HMO, Private, Private HMO, Self-Pay, Other; Number of Hospitals: 31

Current MS-LTC DRG	DRG Description	Reporting Hospital Data: # Tot DCs	Total Falls	Falls per 1000 patient days	Falls w/injury per 1000 patient days	Assisted Falls per 1000 patient days	Minor Fall Rate	Major Fall Rate	Benchmark Group Data: # Tot DCs	Total Falls	Falls per 1000 patient days	Falls w/injury per 1000 patient days	Assisted Falls per 1000 patient days	Minor Fall Rate	Major Fall Rate
4	Trach w MV 96+ hrs or PDX exc face, mouth & neck w	1	0	0.00	0.00	0.00			12	0	0.00	0.00	0.00		
194	Simple pneumonia & pleurisy w CC	2	1	28.57	0.00	0.00	0.00%	0.00%	47	3	3.90	0.00	0.00	0.00%	0.00%
195	Simple pneumonia & pleurisy w/o CC/MCC	1	0	0.00	0.00	0.00			22	2	5.26	0.00	0.00	0.00%	0.00%
207	Respiratory system diagnosis w ventilator support	2	0	0.00	0.00	0.00			315	15	1.16	0.15	0.00	0.00%	0.00%
592	Skin ulcers w MCC	1	2	54.05	27.03	0.00	0.00%	0.00%	29	2	2.51	0.00	0.00	0.00%	0.00%
645	Endocrine disorders w/o CC/MCC	1	1	76.92	0.00	0.00	0.00%	0.00%	5	*	*	*	*	*	*

*Falls severity score - Minor (1), Moderate (2), Major (3), Death (4)
Benchmark reports only reflect data for DRGs at the Reporting Facility

Sample Trend Report: Discharge Disposition



Report Type: Trend Report — Report Name: DRG Discharge Disposition — Report Date: 08/18/2009
Hospital Group Description: Hospital Type: Freestanding, Hospital Within Hospital, Satellite of Hospital, Hospital inc. Satellites, Hospital exc. Satellites; Organization Type: Voluntary, Proprietary, Government; Geographic Region: Northeast, South, Midwest, West; Hospital Size: 1-24 Beds, 25-49 Beds, 50-74 Beds, 75-124 Beds, 125-199 Beds, 200-299 Beds, 300+ Beds; Payer Type: Medicare, Medicare HMO, Medicaid / Medicaid HMO, Private, Private HMO, Self-Pay, Other; Number of Hospitals: 42

Current MS-LTC DRG	DRG Description	Reporting Period Q1 2006, 1 Qtrs: # of Discharges	Percent of Patients Discharged To: Acute Hosp %	IRF / Psych %	SNF %	Home %	Died %	Reporting Period Q1 2007, 1 Qtrs: # of Discharges	Percent of Patients Discharged To: Acute Hosp %	IRF / Psych %	SNF %	Home %	Died %
4	Trach w MV 96+ hrs or PDX exc face, mouth & neck w	26	11.54%	7.69%	23.08%	7.69%	34.62%	23	4.35%	0.00%	13.04%	8.70%	56.52 %
40	Periph & cranial nerve & other nerv syst proc w MC	7	*	*	*	*	*	1	*	*	*	*	*
41	Periph & cranial nerve & other nerv syst proc w CC	5	*	*	*	*	*	1	*	*	*	*	*
52	Spinal disorders & injuries w CC/MCC	18	27.78%	0.00%	11.11%	55.56%	0.00%	1	*	*	*	*	*
53	Spinal disorders & injuries w/o CC/MCC	8	*	*	*	*	*						
54	Nervous system neoplasms w MCC	3	*	*	*	*	*						
55	Nervous system neoplasms w/o MCC	7	*	*	*	*	*						
56	Degenerative nervous system disorders w MCC	41	19.51%	7.32%	39.02%	17.07%	7.32%	6	*	*	*	*	*
57	Degenerative nervous system disorders w/o MCC	224	7.14%	3.13%	49.55%	36.61%	1.34%	6	*	*	*	*	*
59	Multiple sclerosis & cerebellar ataxia w CC	3	*	*	*	*	*						

...continued on page 10

Health Reform: What Next?...continued from page 5

- A bundled payment policy changes incentives as to the type of provider in which patient care is rendered. Entities charged with managing[1] a payment bundle should be expected to place patients in the most economical setting consistent with meeting quality and patient outcome goals. This means that patients will likely be transferred to and from hospital or SNF beds based upon considerations of bed availability (i.e., excess beds) and resource availability, rather than exclusively or traditional level of care considerations. Hospitals which experience periods of excess bed capacity may have an incentive to create de facto swing beds and retain in hospital beds patients who may not be at a hospital level of care to help offset fixed and standby non-variable costs. The opposite may be the case for hospitals that do not have excess bed capacity. Bundled payment arrangements, therefore, may serve to misalign the traditional relationship between use of Medicare hospital and SNF benefits with established level-of-care definitions. A diminution of traditional level-of-care requirements could result in the following distortions to the Medicare benefit package which could disfavor Medicare program beneficiaries.
- Under current IPPS and LTCH-PPS payment systems, the count of beneficiary days is suspended in a hospital when a beneficiary has reached the geometric ALOS for the applicable DRG and is only resumed when the patient qualifies for high-cost outlier status. SNF benefit days are calculated in a different manner i.e. on a per diem basis. Therefore, to the extent bundled payments result in an incentive to substitute non-hospital SNF services for hospital services or vice versa a distortion in the count of benefit days and co-insurance and deductible beneficiary obligations will occur. A change in the manner in which Medicare benefit days are accrued toward spell of illness day limitations has implications for the timing of Medicare beneficiary day benefit exhaustion and related time of payment liability by Medigap , other secondary payor insurers and Medicaid program liability.
- For a number of reasons it may not be feasible or desirable for CMS to discontinue Medicare coverage for patients who would have exhausted Part A benefit days during a hospitalization, but who continue to receive inpatient services for a longer time period because they receive services as part of a bundle payment pilot project. Among other things, CMS would be required to determine patient cost outlier status under the applicable, MS-DRG payment system. Current law does not contemplate a partial bundled payment episode of care or partial payment amount. Additionally, "episode of care" covered by bundled payment extends 30 days from discharge from a hospital. The law does not address the question of whether a beneficiary's covered Part A hospital and SNF days could end at an earlier time than the "episode of care" which is covered by bundled payment. Secondary payors likely would conclude that Medicare responsibility continues, with respect to a medical condition included in a bundled payment pilot for a 30 day period after an inpatient hospital discharge. Secondary payors (Medgap insurers and Medicaid Programs) could become an unintended beneficiary of any extension of the Medicare program's policy to continue coverage for an entire "bundled episode" of care even if exhaustion of benefits would have occurred at an earlier time under the fee for service payment system. Additionally, to the extent that bundled Medicare payments include post acute care services, secondary payors who recognize that "bundled" payment incentives may operate to blur the traditional alignment of SNF and hospital levels of care may have difficulty determining whether secondary coverage is available and, if so, whether to pay for hospital or SNF services and related Medicare beneficiary co-payments. A shift of Medicare secondary and Medicaid liability to bundled Medicare payments could conceivably adversely affect the economic viability of Congressionally mandated budget neutrality of bundle payment pilot project payments.

Potential Correction of Distortions:

1. Provide Medicare beneficiaries who participate in a bundled payment pilot program with a waiver of co-insurance and deductible obligations for both hospital and SNF services.
2. Provide that benefit days are calculated as if beneficiaries did not participate in the bundle payment pilot and continue to make level of care determinations under traditional medical standards, regardless of the provider classification of bed in which the beneficiary receives care to assure a correct count of benefit days. CMS would make necessary changes to its administrative processes to provide the common working file records a correct count of beneficiary benefit days.
3. Issue exhaustion of benefit notices at the same time as would be the case under the fee for service payment system to accurately mark the time of secondary payor and Medicaid program financial liability.
4. Install a budget neutrality requirement for Medigap, other secondary payors and Medicaid programs which insures that bundled payments which derive from the Medicare Part A trust fund are not substituted for third party insurance and public assistance liability/payments which would have occurred had bundled payments not been made.
5. Provide that Medicare secondary payments and Medicaid payments are made to providers who participated in bundle payment pilot programs at the same time and in the same amount as would have occurred with the absence of the a bundle payment pilot project. New statutory authority may be required to institute these recommendations.

Questions concerning this Statement should be directed by electronic mail to NALTH's General Counsel, Ed Kalman at ekalman@beharkalman.com.

Note

1. E.g., Hospitals and Accountable Care Organizations (ACO).

NHIS: An Innovative Performance Benchmarking System for LTCHs

...continued from page 8

Financial and Operations Reports

NHIS also provides timely financial reports. NHIS Subscribers submit quarterly patient discharge information and the system does a number of calculations for reports that include:

- Case Mix index
- Discharge and length of stay
- Payment and margin
- Cost per discharge and per day
- Medicare payment type

All reports provide detail by MS-LTC-DRG and are important for operations and financial performance management. To enhance NHIS Subscriber-provided data, The Lewin Group adds Medicare Provider Analysis and Review ("MEDPAR") data from all LTCHs throughout the country as soon as it is released by CMS. NHIS reports for rate year 2008 have financial and operations information for over 390 LTCHs nationwide.

To enable meaningful trending and comparison over different timeframes, NHIS runs all current and historical data through a Medicare grouper so it always is displayed according to the most recent grouper version. However, the system is sophisticated enough that case mix index and payment amounts are calculated based upon the payment system that was in place at the time each patient was discharged. The system also calculates interrupted stays under Medicare rules.

NHIS summarizes information from LTCH Medicare cost reports into an "Operations Report" which includes payor mix, ancillary and routine costs per patient day, charges and financial ratios. Among other things, NHIS allows Subscribers to compute their costs and financial efficiency by LTC-MS-DRG in comparison with peer groups of LTCHs. NHIS Subscriber hospitals can submit information about staffing hours per patient day and compare staffing levels with hospitals of a similar size. Similar to the financial reports above, The Lewin Group loads cost report information onto the system from all LTCHs nationwide, so that information is even more robust.

As another benefit, The Lewin Group places Medicare pricers on NHIS each time there is a proposed or final Medicare rule, which allows NHIS Subscribers to calculate the financial impact of payment changes.

Sample Benchmarking Report: Cost and Length of Stay

Report Type: Benchmarking Report — Report Name: Cost & ALOS — Report Date: 08/18/2009

Reporting Hospital Name: 01-LTCH — Reporting Period: Q1 2006, 1 Qtrs

Benchmark Hospital Description: Hospital Type: Freestanding, Hospital Within Hospital, Satellite of Hospital, Hospital inc. Satellites, Hospital exc. Satellites — Hospital Size: 1-24 Beds, 25-49 Beds, 50-74 Beds, 75-124 Beds, 125-199 Beds, 200-299 Beds, 300+ Beds

Organization Type: Voluntary, Proprietary, Government — Payer Type: Medicare, Medicare HMO, Medicaid / Medicaid HMO, Private, Private HMO, Self-Pay, Other

Geographic Region: Northeast, South, Midwest, West — Number of Hospitals: 41

Current MS-LTC DRG	DRG Description	Reporting Facility Data # of DCs	Reporting Facility Data Original DRG Weight	Reporting Facility Data Cost Per Discharge (Mean)	Reporting Facility Data Cost Per Day (Mean)	Reporting Facility Data Mean LTCH LOS	Benchmark Facility Data # of DCs	Benchmark Facility Data Original DRG Weight	Benchmark Facility Data Cost Per Discharge (Mean)	Benchmark Facility Data Cost Per Day (Mean)	Benchmark Facility Data Mean LTCH LOS
4	Trach w MV 96+ hrs or PDX exc face, mouth & neck w	1	3.2000	139,788	2,026	69.0	25	3.2000	109,421	1,961	55.8
194	Simple pneumonia & pleurisy w CC	2	0.6987	17,975	1,027	17.5	64	0.6987	16,743	883	19.0
195	Simple pneumonia & pleurisy w/o CC/MCC	1	0.6987	10,503	1,050	10.0	26	0.5591	15,804	905	17.5
207	Respiratory system diagnosis w ventilator support	2	2.0831	91,008	1,916	47.5	459	2.0831	83,749	1,607	52.1
592	Skin ulcers w MCC	1	0.8720	45,942	1,242	37.0	38	0.8720	29,511	947	31.2
645	Endocrine disorders w/o CC/MCC	1	0.6376	8,031	618	13.0	6	0.6063	*	*	*
863	Postoperative & post-traumatic infections w/o MCC	1	0.8252	21,143	881	24.0	56	0.8252	24,705	945	26.1
872	Septicemia w/o MV 96+ hours w/o MCC	1	0.8241	5,060	632	8.0	47	0.8241	21,179	866	24.5
	Totals	10	1.2621	44,843	1,541	29.1	721	1.6881	64,100	1,498	42.8

Report Capabilities

NHIS offers 3 types of reports: **benchmarking, trend and comparison reports**. NHIS Subscribers select from a menu of standard reports. They can custom design a benchmarking group according to hospital size, geographic region, hospital type or payor. The web-based design is intuitive and easy to navigate. NHIS Subscribers also can obtain custom reports, for a nominal fee. To assure current information, reports are typically available within 60 days of the close of each calendar quarter.

NHIS Subscribers that select NHIS as their ORYX vendor (at no additional charge) receive additional ORYX reports from The Lewin Group, which include run charts and control charts for each indicator.

Data Submission

Just about all hospitals find that they can readily obtain much of the patient-specific information for submission to NHIS through their Hospital Information System. Once the data download specification is written, data submission to NHIS becomes very quick and routine. The patient-specific quality data is typically gathered by a team of clinicians involved in infection control, risk management and quality improvement. The quality data is submitted through an Excel spreadsheet or Access data-gathering tool. The Lewin Group provides training on data submission by Webinar. They also provide online and telephone support.

Executive Summary Report

This month, NHIS will launch a new Executive Summary report which will include key quality and financial indicators. NHIS Subscribers are looking forward to this new report. According to Cherri Burzynski, C.E.O. of Bay Special Care Hospital and a Vice President of NALTH, "it will be quick and easy to navigate key findings and share this report directly with our Board. Our Board really likes the NHIS information. It gives them the LTCH comparison information they have been seeking for years."

For Further Information or a Web Based Demonstration, contact:

Susan Glasser, NHIS Contract Manager at 781.224.2450 or sglasser@benchmarkhealthcare.org

Note: Sample reports are from the NHIS Training site without real data. All reports are under NALTH's copyright and may not be reproduced without prior written permission of an Officer or the General Counsel of NALTH.

NHIS Key Features

- Web-based
- Comprehensive
- LTCH-specific
- Subscriber-driven, flexible design
- Cost-effective

2010/11 NALTH BOARD OF DIRECTORS

Please welcome the new NALTH Board of Directors elected by the membership during the NALTH Annual Meeting held April 29 and 30, 2010 in Washington DC:

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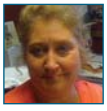

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Madonna Rehabilitation Hospital, Lincoln, NE

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(NALTH Board Member & Past President)
Barlow Respiratory Hospital, Los Angeles, CA

NATIONAL ASSOCIATION OF LONG TERM HOSPITALS
NALTH

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NALTH

2010 EDUCATIONAL CONFERENCE

Multidisciplinary Frontiers in Treating the Long Term Care Hospital (LTCH) Patient
with an LTCH Coding Update: Documentation & Reimbursement Track

October 21-22, 2010
Treasure Island Hotel – Las Vegas, NV

A program for LTCH Nursing, RT, PT, OT & Speech & Coding. Please make your staff and contractors aware of this unique program.

Preliminary Program

THURSDAY, OCTOBER 21

CONCURRENT SESSIONS:

Connections: Breathing & Postural Control
Integrating Cardiopulmonary and Postural Control Strategies in the Adult and Pediatric Population
Presenter: Mary Massery, PT, DPT

LTCH Coding Update: Documentation & Reimbursement
Presenters: Ella James, Edward Kalman, Esq (NALTHGeneral Counsel), Barry Libman, Sue Marre

FRIDAY, OCTOBER 22

GENERAL SESSIONS:

Diaphragmatic Abdominal Pacing: Benefits of Strengthening the Diaphragm Muscle
Presenter: Anthony F. DiMarco, MD, Case Western Reserve University

Negative Pressure Wound Therapy (NPWT): State of the Science
Presenter: Mary Arnold Long, MSN, RN, CRRN, CWOCN-AP, ACNS-BC, Drake Center

POSTER SESSION

NALTH QUALITY AWARD RECIPIENT PRESENTATION AND AWARD PRESENTATION

MANAGING PATIENTS, FAMILIES AND DOCTORS WHO WANT AGGRESSIVE CARE IN FUTILE SITUATIONS – A PANEL DISCUSSION

ABSTRACT PODIUM PRESENTATIONS

Speakers invited; Program subject to change.

Credit is being sought for multiple disciplines and will be disclosed in registration materials. Determination of credit is pending. WellStar Health System is a co-provider of this conference. **WellStar Health System** is an approved provider of continuing nursing education by the Georgia Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.