QMs make a comeback: Here’s what to do
Caralyn Davis, Staff Writer

On April 19, the Centers for Medicare and Medicaid Services (CMS) is expected to post the first MDS 3.0-based quality measures (QMs) on the public website, Nursing Home Compare. That release represents the leading edge of what amounts to a quality-focused tidal wave that is bearing down on the nursing home industry. At some point, CMS also will begin re-incorporating QMs into the survey process. (Note: CMS has stopped using the term quality indicators, or QIs.) In addition, the agency is currently developing regulations that will require nursing facilities to implement a five-part Quality Assurance and Performance Improvement (QAPI) program in conjunction with ongoing mandated Quality Assessment and Assurance (QAA) activities.

When Disaster Strikes
Betty Frandsen, RN, NHA, MHA, C-NE

Wednesday morning September 7, 2011—a day in nursing homes across the Southern Tier of New York and the Northern Tier of Pennsylvania that began like any normal day. Medications were given, doctor calls were made, meals were served, and residents received needed care. However, this day quickly turned into a nightmare of epic proportions due to the fact that it had been raining hard all night. With the dawning of September 7th there was no letup from Tropical Storm Lee, which stalled over the region. Staff and residents were concerned by late morning as they recalled a similar weather pattern in June 2006. That previous storm caused small stream and river flooding and necessitated the evacuation of two nursing homes – a 180 bed facility moved into a school for a week, and a 77 bed facility transferred residents into empty beds in neighboring facilities for several months while repairs were made.

By noon on September 7th many roads were flooded, as small creeks and streams overran their banks. Schools dismissed early even though it was the first day of the school-year, and

First you are young; then you are middle-aged; then you are old; then you are wonderful.
—Lady Diana Cooper

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What Do You Do When You Are Faced With An Immediate Jeopardy!

Immediate Jeopardy! How can that be, we are a good home! Those two words cause instant panic and disbelief. But the reality is you may be faced with an Immediate Jeopardy citation any day, any time. Nursing Homes cited with Immediate Jeopardy may receive civil money penalties ranging from $3,050 to $10,000 for each day that the Immediate Jeopardy exists.

You also are on what is called the “fast-track” for closure. If you do not remove the jeopardy within 23 days you may be faced with termination from the Medicare/Medicaid Program!

According to the American Health Care Association, Trends in Nursing Facilities Standard Health Survey Citations—June 2011, the percentage of nursing facilities with Immediate Jeopardy citations in 2011 was 2.5%, down from 2.9% in 2009. Although that is a good sign, the number may be actually higher in your particular State. According to federal data, the top three federal citations for Immediate Jeopardy include:

- F323 Accidents
- F309 Quality of Care
- F225 Abuse

Immediate Jeopardy is defined as: “A situation in which the provider’s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.” (See 42 CFR Part 489.3.). Serious harm, injury, impairment, or death does NOT have to occur before considering Immediate Jeopardy. The high potential for these outcomes to occur in the very near future also constitutes Immediate Jeopardy.

When citing IJ, the surveyor looks for facility CULPABILITY:

- Did the facility know about the situation, and if so, when did it first become aware of it?
- Should the facility have known about the situation?
- Did the facility conduct a thorough investigation of the circumstances surrounding the incident?
- Did the facility implement corrective actions?
- Did the facility continue to look at the corrective actions and measures that were put in place to make sure they were working and the situation was corrected?

It all starts with your investigation into an incident or complaint and should also focus on these same questions to help develop a complete and thorough investigation summary.

As a Regulatory Compliance Consultant for Healthcare Compliance Group in New York State, we assist facilities in dealing with the IJ citation from the time the DOH even mentions the words—Immediate Jeopardy. The facility must respond to each potential IJ swiftly and concisely. By doing so, you may forestall an IJ citation or in the very least “go in and go out” of IJ simultaneously.

I have been in long-term care for over 35 years holding all positions within the nursing department, including MDS Coordinator, and Director of Nurses. I had the privilege of being with a facility that had perfect certification surveys throughout my tenure as Director of Nurses and coupled with my work as a Regulatory Compliance Consultant have extensive experience in dealing with the regulatory process and the prevention of deficiencies.

I will be giving a presentation at the AANAC Annual Conference in Jacksonville, Florida on April 20, 2012, which will focus on systems each facility must have in place to PREVENT Immediate Jeopardy and how to respond once you are faced with an IJ.
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But wait, there’s more: By March 2013, skilled nursing facilities will be required to have mandatory compliance programs in place as a Medicare condition of participation, and going by the existing voluntary guidance from the Office of Inspector General, quality of care will be a critical component of those programs as well. Add in various quality-focused payment demonstration projects and the American Health Care Association’s attempt to pursue quality-related alternatives to payment cuts in the ongoing federal budget battle, and providers that aren’t paying significant attention to quality of care could soon be in dire straits.

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Traditionally, “facilities have looked at the QMs as an indication of how they are doing in terms of the care they are providing,” notes Rena Shephard, MHA, RN, RAC-MT, C-NE, Executive Editor and master teacher for AANAC, and president/CEO of RRS Healthcare Consulting Services in San Diego.

“When we start chasing bad news on a QM report, we are basically turning our backs on what is going on here and now in our facilities.”

The linchpin of a strong upfront approach is quality improvement, says Shephard. “Not only do we need to develop and implement good resident care systems, but we must have robust monitoring systems in place to make sure that those resident care systems are functioning as intended. With good monitoring systems, we can identify fairly quickly if a resident care system stops working the way it is supposed to be working. That allows us to fix the system before it becomes an adverse trend that shows up on the quality measures or in the survey or in any other negative way, such as a lawsuit or bad outcome.”

The April posting of the publicly reported QMs should be a jumping off point to lay the groundwork for a quality improvement program, says Shephard. “In the long run, if the people in the facilities will invest the time and the effort upfront to do this, then they are not going to be chasing after bad news on the back end. It’s going to save them a lot of time and it is going to show in their quality measures for the survey process, as well as for the publicly reported quality measures. And by the time QAPI goes into effect, they will already be rolling. The payoff will be enormous, but they have to make that investment upfront and on a continuing basis.” (For more information, see page 5.)
That said, there are still some basic steps required for successful management of the QMs. These include the following:

**Learn the definitions**

With the MDS 2.0-based QMs, “there was a big gap in understanding what the measures actually meant,” says Carol Hill, RN, BSN, RAC-MT, C-NE, CDP, president of Hill Educational Services Inc. in Warrior, Ala., and an AANAC master teacher. “Sometimes facilities started looking at processes and systems that had no impact on the QMs. So staff need to be familiar with the definitions of the quality measures, specifically the numerators, denominators, exclusions, and covariates, so that when they look at a measure, they know exactly what part of the care within their facility that measure is related to.”

All the staff in the facility should be familiar with the QMs, says Hill. “The nurses on the floor need to know how the jobs they do impact back on the quality measures. Even the nursing assistants should have a basic idea of how the care they provide relates to the measures. Educating the team will help give them a sense of ownership in improving or maintaining the facility’s percentages.”

Three people need to have a firm grasp of how the QMs work: the MDS coordinator, the director of nursing, and the administrator, says Hill. “They must have the knowledge. Otherwise, the facility’s response to high-triggering QMs will lack cohesiveness and sustainability, and the facility will be spinning its wheels.”

However, three people need to have a firm grasp of how the QMs work: the MDS coordinator, the director of nursing, and the administrator, says Hill. “They must have the knowledge. Otherwise, the facility’s response to high-triggering QMs will lack cohesiveness and sustainability, and the facility will be spinning its wheels.” (The draft MDS 3.0 Quality Measures User’s Manual is currently available on the MDS 3.0 Technical Information webpage. At press time, CMS is expected to issue a finalized manual sometime this month. Watch the “Need to Know” section of the AANAC homepage for news.)

**Review the preview QMs**

While no QMs will be publicly reported until April, facilities should begin their preparations now, suggests Hill. “Don’t wait and get caught off guard. Providers should take advantage of the preview QM information that CMS has released so that they can see how their measures are aligning. If, after reviewing their MDS coding, they identify that they really have a problem in a particular area, they can put systems and processes in place to address the care and make improvements in that priority area.”

(Note: The preview or sample QM reports can be found in each facility’s January Five Star Preview Report in the CASPER Reporting system.)

If the draft manual is all that is available, “go ahead and look at the draft,” says Hill. “The draft manual at least provides a basis of information to understand how CMS selected the records for the various short-stay measures vs. the long-stay measures, as well as what they are considering for the numerators, denominators, exclusions, and covariates. Reviewing your preview QMs in the context of the draft manual allows you to get an idea of where the information is coming from.” When the finalized manual is released, providers will then be able to assess what has or hasn’t changed from the draft and change their decision-making accordingly, she adds.

**Review MDS coding**

The QMs derive from MDS coding, so facilities need to double-check their
Quality improvement: Getting started

One critical barrier to implementing systems-based resident care in many facilities is the lack of the requisite skill set. “Putting this kind of system together can be overwhelming,” says Rena Shephard, MHA, RN, RAC-MT, C-NE, AANAC Executive Editor and master teacher, and president/CEO of RRS Healthcare Consulting Services in San Diego.

“Not all directors of nursing have all of the infinite skills that are required to be successful in that position. So some nursing directors and administrators could benefit from a consultant who specializes in the development and implementation of good quality improvement programs. That investment will pay off, ensuring limited staff time and resources are put to the best use.”

Quality improvement doesn’t work on a “hit-and-miss” basis, she points out. “Facilities need to have a plan. They have to identify areas of weakness or opportunities for improvement in the facility, and they also have to prioritize their needs because they can’t do everything at one time.”

Every facility is required to have quality assessment and assurance (QAA) committee, notes Shephard. Many QAA committees waste time writing last-minute reports to fulfill paper compliance. A more useful approach would be to have the QAA committee act as a steering committee for quality improvement. “Then facilities could form subcommittees with the expertise and the interest to tackle specific issues, whatever the priorities are.”

That model is a starting point, stresses Shephard. “Staff should meet and discuss what structure will work best for them. But the QAA committee members typically are much more inclined to do their work if they have defined tasks and aren’t responsible for monitoring everything there is to monitor in the facility.” (Shephard’s “how-to” book, Quality Improvement and the Nurse Leader, is available through AANAC’s Online Store.)

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coding accuracy, says Hill. “Your measures will be reflecting inaccurately if the coding of the MDS is not correct. Sometimes higher percentages are a simple coding issue from the very beginning, so providers should always work to make sure that the MDSs are coded appropriately.”

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anyone who looked was stunned to see that the usually calm Susquehanna River was roaring, and rapidly rising past flood stage of 30 feet, eventually cresting at just below 40 feet. As hours passed most of the 3 – 11 shift did not make it in. By 5 pm the 180 bed facility began preparing to evacuate, as water advanced toward their building and threatened to overtake the generator. Their residents were transferred into empty beds in other area facilities located on higher ground. By midnight when this evacuation was completed, the building was taking on water that over a period of two days filled the lower level and rose into the first floor for a total depth of 15 feet. Because this was the second flood in five years, the owners decided not to reopen at that site.

In the neighboring county 20 miles to the west, a 77 bed facility situated on the bank of the Susquehanna River assessed their situation and thought they would be safe, in part because the village had made modifications to runoff water management after the 2006 flood. By morning their building was surrounded by flood water, and when they made a call for assistance, no one could get there to help. Widespread power outages had occurred during the night, and the telephone circuits in the entire town stopped working. Staff relied on personal cell phones to try to keep in touch, but eventually the cell towers began to fail. Staff quickly realized they had to keep their residents safe right where they were. The generator was running, but the transfer switch located in the basement was not functioning, as the entire basement flooded to the ceiling—and the water was now rising into the first floor. Sixteen employees remained marooned with 70 residents, and everyone worked together to provide care, fix meals, and keep residents calm. Staff moved the residents into an adjoining building used for outpatient therapy and adult day care because it was at a higher elevation than the nursing home. Two long nights were spent giving care by flashlight. Meals and snacks were provided from the previously planned emergency food and water supply. Staff took turns sleeping in short shifts. All possible measures were taken to care for the residents by remaining in place.

By morning their building was surrounded by flood water, and when they made a call for assistance, no one could get there to help.

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When Disaster Strikes, continued from page 6

On Friday the water began to recede, and help arrived in the form of the National Guard who carried residents from the facility on stretchers and transported them to a central coordination area. Shortly thereafter, efforts began to relocate all residents to two facilities in another county where they still remain. Despite the gravity of the situation, many of the ladies enjoyed being evacuated by the handsome men in uniform that came to rescue them, and there was much laughter. The best news from the disaster was that there were no injuries or deaths from this epic flood, yet the damage to property remains beyond calculating. These facilities, as well as a third one that flooded just to their south in Pennsylvania, remain empty.

What would the staff of these facilities like to share with us? First they say, even though there was a good evacuation plan in place with an all-inclusive multi-county mutual aid disaster protocol previously viewed by the Department of Health as a model in the state, when a disaster is of such great proportion, the protocols were simply not adequate. For example, once the 180 bed facility was evacuated, there were no local beds left to which the second or third facilities could evacuate. Even the four area hospitals were surrounded by flood waters. Roads were closed, and there was no safe passage over which to take residents to more distant available beds. Second, it is best to err at night when visibility is poor and roadways may be compromised. As staff at the smaller facility pondered the events that occurred, they realized that if the residents had been evacuated to an off-site coordination center, because the roads beyond there were no longer passable, they would have been stranded without beds, linens, and many other items necessary to meet their needs. In this situation the facility's residents were actually safer than if they had left the building and encountered danger on the flooded roadways.

The overarching lesson of this unpredicted disaster is that we as nurse leaders must think beyond the scope of typical evacuation plans. Our disaster plans must be designed so that if we cannot leave the building, our residents' needs are still met to the best of our ability. Evacuation plans are based on the premise that an event has occurred necessitating either a full or partial evacuation of the facility. However, the plans should only be activated when it is certain that destinations chosen for the evacuees are safer than the area being evacuated. None of us know when disaster will strike. Therefore, before it happens to us, we must review our disaster and evacuation plans with the understanding that they may not be feasible, and create additional options should we not be able to proceed. So many vulnerable people are depending on us.

It is best to err on the side of caution, and don't wait till you are getting into danger to begin an evacuation. It is better to act when not necessary than to fail to act when evacuation is still possible.

Therefore, before it happens to us, we must review our disaster and evacuation plans with the understanding that they may not be feasible, and create additional options should we not be able to proceed. So many vulnerable people are depending on us.
The answers to this crossword can be accessed in the January 11 LTC Leader.

Across:

1. The IOM “Future of Nursing” report recommends 80% of nurses achieve this level of education.

2. In 2011 AANAC made this change to our name.

4. The IOM report recommends expanding leadership opportunities for this group.

5. When asking for help with the MDS, IDTs should do this regarding the efficiency of their MDS documentation system.

9. Location of the AANAC Spring Conference.

10. The winner of the AANACConnect profile contest was Genie _____________.

Down:

2. Last summer the AANAC board joined AHCA for this briefing.

3. This is the name of the AANAC discussion group.

6. HHS announced it will award 33 grants totaling $10.9 M for nursing education, practice, quality and _____________.

7. The number of young adults entering nursing is on track to be ____________ than ever before.

8. Be aware of the different assessments on the MDS so you don’t ____________ your efforts.

11. Each time you set this, you effectively reset the CoT observation window.
Resident completed PT/OT on Jan. 26 but continued with daily skilled IV hydration via PICC due to medical necessity. We are teaching her husband how to provide for this skill at home. The EOT OMRA was dated Jan. 26. Would a better choice have been day 3, after the end of therapy, or Jan. 29? What would be the best choice for the ARD if resident continues with daily skilled nursing?

Your ARD would have to be Jan. 27, 28, or 29. Pick the best date that results in the best nursing RUG. Another consideration is the COT date. If the 7th day of the COT observation period is one of those three days, you would want to complete the EOT OMRA on or before that date to avoid a COT if the RUG would go down.

Ronald A. Orth, RN-BC, CPC, RAC-CT
(raorth@clinicalreimbursement.com)

The director of therapy at my facility says that we cannot count therapy minutes that a resident gets on discharge from facility or discharge from therapy. Is this true? If a resident attends therapy in the morning and then in the evening is discharged to the hospital, can we take credit for those minutes? Or if a resident is discharged from therapy and Part A coverage on an ARD date, do we need to exclude any minutes of therapy received on that day?

Your therapy director is misinformed. When a resident is discharged, it is often appropriate to combine the PPS assessment with the discharge assessment using the date of discharge as the ARD. The RAI manual instructs us to code skilled therapy minutes received by the resident in the last 7 days, including the ARD. It would be incorrect to NOT include those therapy minutes provided on the ARD. Code all skilled therapy minutes provided in the last 7 days (since admission) on each MDS even if they are provided on the day of discharge.

Carol Maher, RN-BC, RAC-CT
(cmahero121@earthlink.net)

I have an assessment with ARD of Feb. 21, which is day 92, for an OBRA Quarterly. The resident was sent to hospital today, Feb. 14, and was admitted. How do I satisfy the OBRA assessment that is due, since she is in the hospital?

You have 14 days after the A1600 reentry date when the resident returns to complete an OBRA assessment that was due while in the hospital. This is on page 2.35 in the RAI User’s Manual:

If a SCSA is not indicated and an OBRA assessment was due while the resident was in the hospital, the facility has 13 days after reentry to complete the assessment (this does not apply to Admission assessment).

Rena R. Shephard, MHA, RN, RAC-MT, C-NE
(RR2000@aol.com)

I have been a Director of Nursing for 18 months, and am frustrated and discouraged. How do I decide whether I am in the wrong role or burned out?

Every day in long term care is demanding, and the same issues do rise up. However, if you see a trend, there may be an inadequate system in place, staff may be improperly trained, or some team members may be intentionally cutting corners. Re-educate them so they understand exactly what they are to do, and then require them to meet those standards. Address one issue at a time so that you are not overwhelmed, and they are better able to comply. This will strengthen you in your role.

The other part of your question addresses burnout. So many people look to a DON to solve problems. This can lead you to feel drained unless you learn to reduce your stress. Burnout has many root causes. If you are physically or emotionally exhausted, things seem to pile up, and you feel overwhelmed. Take a few minutes to ask yourself the following questions:

- Do I take time every day to do something fun?
- Do I have healthy eating habits or do I grab food on the run?
- Am I able to set boundaries so I am not overextended?
- Have I learned to delegate to others?

If you answered “No” to any of these questions, begin taking better care of yourself. You cannot give your best to your important role if you do not first invest in yourself. Focus on your own wellness and select healthy goals, and you will once again feel inspired and capable of inspiring others. As you adopt healthy work and lifestyle habits, you will recapture the enthusiasm and stamina you knew before.

Betty Frandsen, RN, HHA, MHA, C-NE
(bmacfran@gmail.com)

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An EOT-R may be used “in cases when the resident will be unable to resume his previous therapy regimen, then the provider said Kane. “If the provider is unsure if this is appropriate, for example, if therapy was planned to resume therapy on Tuesday. However, if the reason that you missed therapy was that the person had to go to therapy, perhaps due to a family visit or a doctor’s appointment, but he or she will be getting the kind of care that we will all want for ourselves one day and shows your commitment to positive outcomes.

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APRIL 2012 MDS 3.0 UPDATES AND SECTION M REVIEW

Presented by: Jennifer Pettis • Friday, March 16th at 2 pm ET

The April 2012 MDS 3.0 updates contain enhanced coding guidance, new and revised MDS 3.0 items and changes to discharge assessments. During this Webinar, Jennifer will highlight upcoming changes communicated by CMS and will also discuss key Section M areas including those addressing wound measurement and documentation of stage and present on admission which can have critical financial, public reporting and survey implications for facilities.

After the webinar participants will be able to:
• Determine pressure ulcer measurements to include on the MDS 3.0
• Describe staging and determination of “present on admission” pressure ulcers
• Identify records requiring modification or inactivation
• Describe the correct use of the code of “8” when coding A0DLs
• Discuss the significant updates to “Section Q”—return to the community.
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# AANAC 2012

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<td>New York, NY</td>
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<tr>
<td><strong>MEDICARE UNIVERSITY WORKSHOPS</strong></td>
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<tr>
<td>Harmony Healthcare International</td>
<td>Jennifer Pettis</td>
<td>June 4 – 6</td>
<td>Charleston, SC</td>
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The workshop schedule is subject to change and is updated regularly. To see a full AANAC Training Partner workshop schedule, visit aanac.org/workshops
A wealth of information to get you started on AANAConnect

Whether you’re new to the association, or maybe just new to professional networking, there’s never been a better time to start investigating one of our snazziest member benefits, AANAConnect. This “members-only” online community puts the power of numbers at your fingertips giving you the opportunity to network and share with thousands of AANAC members and LTC experts. We know that new can sometimes be a little intimidating; remember the MDS 3.0 when it was new? That’s why we’ve created a variety of resources to give you simple steps to start making the community work for you.

- View the “Getting Started with AANAConnect” webinar. This video walkthrough of the community will give you the basic information necessary to manage your profile, post questions, connect with other members and download from a vast peer-shared resource library full of best-practices, worksheets, calendars and so much more.

- Want something quicker? Download the “Getting Started Guide” that contains much of the same information as the webinar in a printable format that you can keep by your side as a handy reference guide when a question arises.

- View past issues of “The LTC Leader” in the AANAC archive for a variety of “What’s New in AANAConnect” articles covering topics like subscription settings, white listing, profile management and email link functionality.

- View the Frequently Asked Questions list to see answers for our most common questions.

- Is there something else we can do to help? Email Membership Manager, Shannon Johnson, and let her know how we can help make AANAConnect work better for you.

continued on page 15
What You Need to Know

Check out these latest updates from the “Need to Know” section of the AANAC homepage and find the information you need to get the job done right.

MDS Submissions: AT&T Connection Will Be Disabled on 2-29-12
MDS 3.0 Provider User’s Guide UPDATED
CMS Releases Data on Impact of FY 2012 Policy Changes (1/12)

Coding Tip

Use the Self Performance Algorithm on page G-6 of the RAI Manual to help clarify how to code ADL assistance levels.

Treatment of Members Policy

AANAC has posted the Treatment of Members Policy on the website. If you need to access it, please click here.

FAQ referral

Do you have a question you need answered NOW? Members of AANAC can go directly to the experts! Go to the FAQ section of the website. The answer may be right in front of you!

MDS Crossword Answer Key

The correct answer to the question regarding locomotion off unit in the February 7 Cue up the Codes is “1 – supervision – no rule of 3 applies.” See the algorithm on page G-6 of the RAI manual.

Pardon our error!

Q + A, continued from page 9

For multiple physicians’ order sheets, is the physician required to sign each page of the order sheet, or can the physician just sign and date the last page? Thanks for your help.

F386 Physician Visits requires the physician to:

• Review the resident’s total program of care, including medications and treatments, at each visit required by paragraph (c) of this section…
• Sign and date all orders… which may be administered per physician-approved facility policy after an assessment for contraindications.

A physician who only signs the final page of a multiple-page set of orders does not demonstrate his or her review of the unsigned pages. Further, choosing to only sign the final page does not meet the intent of sub-point (3) which requires that all orders be signed and dated. Every page needs to be signed and dated to document that the physician has actually reviewed the medication and treatment orders. You can obtain a copy of F386 Physician Visits to share with the physician in question by visiting http://www.cms.gov/manuals/Downloads/som107ap_pp_guidelines_ltcf.pdf, Appendix PP of the State Operations Manual. Scroll down to §483.40(b) to locate F386.

Betty Frandsen, RN, NHA, MHA, C-NE (bmacfran@gmail.com)
Introducing: “The 2012 AANAC annual conference” community

When you register to attend the 2012 AANAC annual conference, you will automatically be subscribed to our brand-new conference community. For the first time ever, you will be able to start connecting and learning from other attendees and speakers before the event begins and continue your learning after the conference concludes.

In this community, we encourage:

- Networking and sharing topic/discussion ideas with this year’s speakers
- Meeting peers that will also be attending conference
- Asking questions in a private community before you even get there
- Downloading additional resources and helpful information

Of course there are many other benefits you’ll gain from attending our event. Visit the conference website to learn all about our new learning tracks, expanded schedule, product theaters/demos and more. Register today and start connecting through our most powerful benefit yet, AANACConnect.

Most Active Members:

Patricia Arredondo
San Antonio, TX US
2324 Points

Elizabeth Gonzalez
Oxnard, CA US
938 Points

Roxie Maceda
Ensign Group
West Covina, CA US
919 Points

Terry Hellman
Tulsa, OK US
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Friendship Health and Rehab Center
The Goodman Group
Goshen Care Center
Greystone Health Care Management
Hattiesburg Medical Park Corporation
Health Dimensions Group
Horizon West HealthCare, Inc.
Kingston Healthcare Company
Kissito Healthcare
Lexington Healthcare
Lutheran Senior Services
Magnum Health Care Management
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NHS Management LLC
Paramount Health Care Company
Pinon Management Plantation Management Company
Plott Healthcare Preferred Care Partners Management Group
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Rockport Healthcare Services
SavaSeniorCare
Senior Care Centers
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WE’RE WITH YOU EVERY STEP OF THE WAY.

Find out more at aanac.org

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