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Industry Update

Skilled Nursing

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McKnight's LONG-TERM CARE NEWS

Article One: The Future of Post-acute Care is Visual

Written by: Brian Wallace

Visual communication could help long-term care industry professionals make sense of data overload and understand the issues faster. The result could be reduced costs, increased efficiency and increased quality.

As an outside influencer to the long-term care space, I've discovered a rising trend in healthcare marketing like I've never seen before in my 13.5 years (and 10–11 years in infographics, specifically) in the marketing space. Of particular interest to me is the

senior living arena. I've noticed several trends influencing patient quality as a result of the economic status in the business of long-term healthcare. Unfortunately, there is a rising tide in nursing homes — with specific regard to overspending, waste and improper Medicaid reimbursement. What can be done?

As they say, a picture is worth a thousand words. For those who do not understand all of the nuance in the long-term care industry, it's essential that we connect with people on a visual, emotional level before trying to bridge the gap in our data findings. Infographics seem to be just the delivery vehicle for this powerful message at a critical juncture within this industry.

Telling the story

To see what I mean, please take a look at the infographic here from Prime Source Healthcare Solutions. In this visual way, we can convey information to the average person in a way they understand. As we all know too well, the story starts with this premise: More than half of Americans will need some form of long-term care in their lives. In fact, 1 in 7 people over the age of 65 will need to rely on extended care for over five years, making the need for quality care even more important.

In other well-recognized post-acute trends, costs are rising, yet the quality of nursing home care may be suffering. The economy for U.S. nursing care will reach more than $737 billion by 2026; however, nursing homes have experienced peak record closures over the last 2 decades. At one point, 44% of U.S. patient beds failed to meet fire and health standards. Furthermore, labor costs are rising. There is an extreme shortage of skilled caregivers in our current economic stage. Paying overtime to limited staff only comes by default, but facilities are being left with few choices but to offer higher wages

to attract talent. Either way, labor costs rise — as cutting back on staff would translate into decreasing quality of care.

Coincidentally, 60% of nursing home residents received public assistance around the time it was found that 44% of U.S. patient beds failed to meet fire and health standards in 1965. Today, that number has risen to 67%. In 2018, there were 52 million citizens aged over 65. By 2060, that number will practically double. Who is paying for their care?

Medicaid and Medicare contribute to the equation, but they also do equal — if not more — damage along the way. Here's how it works: Medicare pays for the patient's first 20 days of long-term, and then they subsidize the cost of days 21–100. After that, on the 101st day, the patient is responsible for $50,000-$100,000 annually, depending on the facility's fees. Once the patient diminishes their assets, Medicaid will kick in to cover the remaining balance.

Partnering with Prime Source

After collaborating with Prime Source Healthcare Solutions and taking my industry knowledge into account, I believe maintaining a high standard of resident treatment and care should be atop every priority. Michael Greenfield, whose background is extensive in the field of long-term care, has recognized a gap in the post-acute care industry. Greenfield is the CEO of Prime Source Healthcare Solutions and, to continue sustainability in the changing post-acute care industry, brought together experts in specific disciplines to provide effective best-practice, cost-management solutions that empower owners and operators to optimize service delivery and reduce costs while increasing quality.

According to Greenfield, “Our team collaborates with facility administrators, operators and food service, clinical and procurement directors to continually develop best practice solutions and cost performance pathways specific to the needs of clients. Add in our abilities to maximize vendor contracts, best practice procurement management and other facility-focused services, Prime Source Healthcare Solutions provides a fresh and flexible perspective in a rapidly changing industry.”

Cost management

It begins with cost management.

To business leaders in the industry: improve your efficiency. Carefully collect, evaluate and report your spending data. This can be implemented in simple ways, such as making more frequent deliveries to reduce excess inventory and free up cash.

Overall, nursing homes are struggling for an array of reasons, but there are many ways to make long-term care obtainable and comfortable for the resident.

A new way forward

Greenfield and Mark Zimmet are both recognized and trusted leaders in the post-acute care market. Together with Josh Silverberg and a network of like-minded long-term care procurement professionals, they developed and launched SHOPP, the Society for Healthcare Organization Procurement Professionals, a new educational organization to ensure the success of the procurement professional and increase their role in long-term care facilities.

Brian Wallace is the founder and president of NowSourcing, an industry-leading infographic design agency based in Louisville, KY, and Cincinnati, OH, collaborating

with companies that range from small businesses to Fortune 500s. NowSourcing is the go-to resource for visual storytelling in the crypto / blockchain market, representing numerous cryptocurrency-related publications, ICOs, and others getting press and funding in the space. Brian also runs #LinkedInLocal events all over the country, hosts the Next Action Podcast, and has been named a Google Small Business Advisor for 2016–present.

To see this full article, click here.

Skilled Nursing News

Article Two: Based on Early Readmission Success, Excelsior Plots Skilled Nursing Telemedicine Expansion

Written by: Lyndee Yamshon

With skilled nursing centers providing more acute care than ever, telehealth services such as wireless EKG and remote monitoring can help staff identify issues early, assess patient needs and provide care without having to transport the patient. In its infancy, telehealth is expensive but time will tell if it can save costs in the long run.

Since the latter half of 2019, an East Coast health care group has used a telemedicine partnership to intervene in 100 potential hospitalizations, and within that grouping, definitively stopped 30 hospital admissions — in a collaboration with a medical device company that provides real-time heart monitoring and remote care.

In an effort to reduce unnecessary hospital trips, the Brooklyn, N.Y.-based Excelsior Care Group LLC has outfitted 284 sub-acute and long-term care patients with a wireless patch to oversee heart health in partnership with medical device company ImagineMIC.

The program is currently active in eight facilities, specifically tracking heart and respiratory rates — and serving as an electrocardiogram (EKG) of individual patients.

Based on the early success, Excelsior Care Group has set up four new similar partnerships on the East Coast in the next few months.

“In general … nursing homes are becoming hospitals and hospitals are coming ICUs. We don’t want to have to send residents to the hospital we can potentially treat … just as effectively,” Excelsior Care Group regional administrator Oded Dashiff told SNN.

Dashiff pointed to 30 clear-cut cases of avoiding hospitalizations due to early detection and intervention, involving a collaboration between the ImagineMIC staff and facility nurses and physicians.

Excelsior Care Group chose the Poughkeepsie, N.Y.-based ImagineMIC after meeting with several vendors of similar products. The health management firm found that ImagineMIC’s device and processes the most effective for residents, enabling a wireless patch to be easily applied to a patient’s chest without needing to be attached to other devices.

How it works

The apparatus, which is the size of a credit card, has a monitor with a wireless battery powered device effective for three days. The patch transmits several data points including an EKG, respiratory rate, and heart rate — which is monitored at a station in

the facility as well as a remote monitoring center to be analyzed by doctors, nurse practitioners, and specially trained physician assistants.

The small device won't hinder regular activities, and residents "can move and function completely normally…[while] they're being monitored, and we want our we want our families to also have the peace of mind that their loved ones are being monitored 24/7," Dashiff said.

Spotting decline earlier

With hospitals experiencing increasing pressure to shorten post-acute stays and nursing homes serving higher-acuity patients, the skilled nursing space may greatly benefit from these kinds of early interventions. And Excelsior Care Group and ImagineMIC aren't the only companies to embark on remote monitoring partnerships.

Real Time Medical Systems, for instance, has grown its telehealth platform by touting its ability to catch problems before they rise to the level of hospitalizations, while other companies such as TapestryCare and Third Eye Health allow nursing home staff to consult with physicians via video link.

The ImagineMIC monitors allow clinicians to catch an impending decline in health with early interventions, but without offering an exact figure, the program is admittedly "very, very expensive," and is not reimbursed by insurance, Dashiff said. The facility must absorb the cost.

Excelsior provides consulting services to its member facilities, which in turn pay ImagineMIC for its services. This service is not reimbursable by the resident's

insurance, and is covered in full by the facility. Additionally, each facility has an independent agreement with ImagineMIC.

“We do that because we really want to provide that next level of care,” Dashiff said, “[which is] the reason why the decision was made at the corporate level … because it would really benefit the residents.”

Some of the first health indicators to watch in order to avoid hospitalizations, for example, is a spike in heart rate, which should prompt care staff to spot problems immediately.

Remote monitoring can be particularly fruitful in the first three days upon admission, potentially the most volatile transition time for a resident’s status. The device allows staff to detect subtle changes at this time, and potentially guide the overall care plan.

Rehab patients also benefit from participating during the first three days because watching vital signs while undergoing therapy makes it easier for patients to push through challenges while feeling safe to do so, an Excelsior Care Group spokesperson added.

Case Studies: Hypothetical and concrete

In the case of a resident affiliated with emphysema, the person might begin deteriorating while experiencing difficulty breathing. In the past, that patient would have taken a potentially preventable trip to the hospital to have X-rays, and then be given nebulized medication and intravenous steroids, while being monitored for a certain amount of time, Dashiff said.

In another example, for a patient experiencing a medical event overnight, the system allows for a “face-to-face visit with a provider who can also access the resident’s medical information, medical record,…all the labs, all of the meds, and now they’re actually seeing somebody so they have the extra measure of comfort,” he said. “Nobody will go through the trauma of being sent to the hospital, sitting in the ER, potentially contracting another bug.”

Dashiff also gave a specific example from Lakeview Rehabilitation and Nursing Center in Wayne, N.J., where staff was able to avert a more serious episode for a resident experiencing a brief episode of cardiac arrhythmia.

“The provider in the MIC consulted with the Lakeview team and the resident’s primary physician in real time, and a cardiology consultation was ordered. The resident’s medication regimen was adjusted, and he became stable,” Dashiff said in an e-mail.

In an age with a variety of budding telehealth companies trying to more efficiently tend to the needs of complex patients, Excelsior Care Group is focused on streamlining its infrastructure to augment care, not to replace doctors and other clinicians.

“It’s not just the technology; it’s the infrastructure, and the company behind it. You can have other telehealth platforms, but who’s behind it? Are they going to be receptive? Is it just data that you’re watching without intervening?” Dashiff asked. “So this is the whole package of having the technology that works, having the team behind it that can actually intervene and interact with the facility staff.”

To see this full article, click here.

McKnight's
LONG-TERM CARE NEWS

Article Three: The Gig Economy's Latest Victim? Healthcare Staffing

Written by: Chris Caulfield

Uber for nurses is slowly replacing the traditional staffing method. It could help facilities meet staffing levels, prevent burnout and allow nurses to choose the shifts that work for them - but the real winners could be the patients who get better care from happier, rested nurses.

The traditional healthcare staffing model isn't working. It's inefficient and expensive for facilities, burning out nurses by strong-arming them into overworking, and putting patients at risk.

When a facility that uses the traditional staffing model needs to fill a gap in their schedule, it results in a time-consuming game of phone tag between facilities, agencies and their agency staff. If agencies can't fill the shifts that facilities need, facility administrators and schedulers have two options — ask their own nursing staff to work overtime, or leave the gap in their schedule unfilled and risk staffing penalties. While both of these options are short-term fixes, they can bleed into long-term issues, like staff burnout and turnover, and poor patient care.

At the end of the day, facilities want to fill their shifts and nurses want to provide the best care possible, while also achieving a healthy work-life balance. However, with the traditional staffing model, neither can do that. There is overwhelming evidence that shows short-staffed, burned-out nurses negatively impacts patient care. Studies indicate that:

- Nurses who work overtime are three times more likely to make medical errors
- High patient-to-nurse ratios are associated with fatigue, emotional exhaustion and low job satisfaction
- Staffing of RNs below recommended levels resulted in increased patient mortality

With those stats in mind, it's little surprise that both nurses and facilities are turning to nontraditional staffing methods, like tech-enabled staffing gigs, to solve their problem.

The gig economy has disrupted broken processes in other sectors. The most famous example, of course, is Uber's disruption of the transportation industry. Instead of trying to hail a cab or calling a taxi company and waiting for them to dispatch a ride, riders can request (or even schedule) a ride in advance with the click of a button and watch their driver's route to them in real-time. For drivers, it offers flexibility to only work when they want, and for the rider, it provides the service they need, but in a user-friendly, on-demand way.

In a similar way, companies that leverage technology and the gig economy are popping up across other industries and, in the case of healthcare, are slowly replacing the traditional staffing model. Just as Uber removed the frustration of hailing a cab, tech-enabled staffing apps are removing the frustration facilities face every time they need staff.

Instead of calling multiple agencies to secure a nurse for a shift, facilities can simply submit shifts into an online platform, which broadcasts the shift to a network of nearby nurses. Nurses in the network can browse shifts available in their app and pick up those that work for them. Facilities get real-time updates when a nurse picks up a shift, when they're on their way and when they've arrived. Ultimately, this model gives facilities and nurses what they need. For facilities, it's a fully staffed floor, peace of mind that they're

operating in compliance with the Centers of Medicare and Medicaid Services' guidelines, and internal staff that isn't overworked. For nurses who participate in gig work, it gives them the flexibility to work on their own terms and build a schedule that works for them and their loved ones.

The most important impact this new model has — even more important than a facility's bottom line or a nurse's schedule — is its ability to improve patient care. More efficient staffing and well-rested nurses mean better care for patients.

While adoption of more efficient staffing technology is picking up, change can be hard — especially in the long-term care staffing setting, which has run on paper schedules and phone calls for decades. With the promise of better patient outcomes, happier, healthier staff and less operational costs, facilities will start to lean into a new way of working.

To see this full article, click here.

McKnight's
LONG-TERM CARE NEWS

Article Four: PDPM Altering Provider Use of Therapy

Written by: Lauren G. Perry

The unintended consequences of the new PDPM may be a decrease in care and patient outcomes. Therapists have asked the DHHS to intervene, but any future change is uncertain.

As skilled nursing facilities and nursing homes are already well aware, there were numerous changes unveiled with the Patient Driven Payment Model when it became effective in October of last year.

These changes significantly impacted how Medicare Part A pays skilled nursing facilities for therapy services. Given this reimbursement change, a major area of impact is to the delivery methods of therapy services, including physical therapy, occupational therapy and speech-language pathology services.

Under the PDPM methodology, the payment for therapy is no longer being reimbursed for the minutes of therapy performed, of course. Instead, the reimbursement is based on the patient characteristics and diagnosis. For the new model, it is essential that the patient's assigned case mix is accurate.

This change in approach may have an impact on the patient recovery, even though improved patient outcome is a goal of PDPM. According to a report in the New York Times, this change has led to skilled nursing homes being forced to reduce the amount of time a patient received therapy services. Additionally, it has led to an increase in concurrent or group setting therapy — which some studies have shown that may not be as beneficial to patients' recoveries. However, it is worth noting that there is a 25% combined cap on the group and concurrent therapy (i.e. regardless of the type of therapy) that may be provided per patient for their Part A SNF stay.

Many therapists have been outraged by the changes in the payment model, feeling their positions are undervalued in the care they offer to their patients. Numerous have signed a petition for the Department of Health and Human Services to intervene. In another perceived blow to therapists, similar new Centers for Medicare & Medicaid Services rules go into effect for health and home care reimbursement on Jan. 1.

While the PDPM methodology is meant to address each individual patient's unique needs independently, it may lead to unintended consequences that could leave the patient with less satisfaction of care, and skilled nursing facilities having to resort to trying various care models that have been unproven. PDPM is leading to uncertainty at the least.

To see this full article, click here.

Provider
LONG TERM & POST-ACUTE CARE

Article Five: Geriatric Medical Skills: Essential to Care

Written by: Karl Steinberg, MD, CMD

Geriatricians provide specialized knowledge that benefit both patients and nursing homes. But with demand outpacing supply, nursing homes are innovating with knowledge-sharing strategies to provide the best possible care.

With today's skilled nursing center patients becoming even more medically complex, it's urgent to have knowledgeable medical leaders at hand.

Along with the well-publicized nursing workforce shortage affecting nursing centers nationally, there is a tremendous shortage of qualified medical specialists in geriatric medicine, and the gap is growing every year.

The geriatric population (usually defined as 65 and up, although some might rankle at being called "geriatric" at that age) is increasing rapidly as the baby boomers hit Medicare territory, while the number of geriatrics fellows being turned out annually is diminishing.

Those who choose to practice this specialty are well aware of its intangible rewards—the opportunity to help people who are vulnerable and ill, the privilege of walking with their patients on the path of their last months and years of life, providing care that helps optimize function, and the satisfaction of helping them explore their priorities and goals—then guiding them and their families to make informed decisions about medical treatments. Having the luxury of longer visit times helps relieve the tyranny of the packed waiting room.

But those intangibles don't resonate with every medical student or resident, and geriatrics will sadly never be as sexy or desirable a specialty as the much more highly compensated surgical specialties like orthopedics and neurosurgery. Indeed, as Provider's readers know, it takes a special kind of person to choose to work with frail elders, especially in skilled nursing centers.

Need for Expertise Escalates

While not every person over 65 needs the specialized knowledge of a geriatrician, the benefits of such training and knowledge clearly are important for many nursing center residents, who have become much more complex and seriously ill in the past decade—especially in the post-acute population. Geriatricians are focused on function and treat the whole patient, not just one body system or illness.

Geriatricians think first about stopping medications (deprescribing) rather than adding additional drugs to already huge medication lists—since often the symptom that's bothering the patient is in fact being caused by one of their other meds, or by interactions among meds.

If they are going to prescribe medication, geriatricians adhere to the mantra “start low, go slow.”

Geriatricians help create realistic expectations about prospects of medical and functional improvement in patients and their families, discussing prognosis and goals of care early and often. And they focus on what is important to patients—recognizing that something as simple and preventable as constipation can cause a host of serious problems, including urinary retention, in addition to making patients miserable. They don’t automatically believe that “more is more” when it comes to medical treatments.

These skills and philosophies of geriatric medical care are obviously of great worth to nursing center residents and their families—and they also help the centers provide appropriate levels of care and rehabilitation, while reducing facility liability by educating patients and families on expected outcomes.

Clearly, the ultimate outcome will be death—and a geriatrician can help this outcome, or others that sometimes accompany patients on their expected trajectory (such as pressure ulcers and dehydration), not feel like a surprise or the result of poor care to patients and their families.

Holdover Meds

It is common to see patients being transferred into nursing centers from acute care hospitals, having been started on multiple unnecessary, inappropriate, sometimes overtly harmful medications while hospitalized. Although prescribed with good intentions, these medications often do more harm than good, and they are prescribed by physicians who are presumably just not aware of the risks and contraindications in elders.

In many hospitals, antipsychotics are prescribed for insomnia, benzodiazepines are prescribed for anxiety or agitation, unnecessary and risky proton pump inhibitors are instituted even in the absence of any gastrointestinal symptoms, ill-advised anticholinergic medications are used for overactive bladder, and the antiquated and dangerous “sliding scale” insulin is still routinely used.

Antibiotics may be inappropriately started for “urinary tract infections” that in fact are just a colonized bladder, or asymptomatic bacteriuria. Many of the medication categories listed above are on the Beers List —a list of medications that are generally felt to be inappropriate for use in older patients.

A physician with good geriatrics knowledge will make it a priority to get residents off these medications, which are likely to result in F tags for unnecessary medications if they are continued. A consultant pharmacist may be able to convince an average nursing center attending physician to stop some of these medications, but there may be a delay and actual patient harm, like falls or delirium.

A high-quality, geriatrics-savvy medical director can work with the nursing center’s consultant pharmacist to help educate less sophisticated attending practitioners in the building, both by doing just-in-time interventions on specific residents and by larger-scale efforts such as sending e-mails, faxes, or paper mail to practitioners about efforts to reduce inappropriate medications, or to improve discussion of advance care planning.

Gearing up for Increased Acuity

In these days of Patient-Driven Payment Model and the reality of extreme medical complexity, a geriatrics approach—sometimes taking a longer view and reducing rather than intensifying treatment efforts—should be a priority for every nursing center. Being

mindful of both post-acute and long term residents' goals of care should always guide the treatment plan, including rehab goals and medication management.

Geriatricians often have overlapping skills with hospice and palliative medicine specialists, another medical specialty that is under-represented but highly valuable to the population. There are increasing numbers of combined geriatrics/palliative fellowships, but the graduates will be nowhere near the number needed to adequately cover nursing center patients in the years to come.

For this reason, engaging medical leaders—physicians, nurse practitioners, and others—who have both the knowledge and the desire to share it with other clinicians should be something that prudent, concerned nursing centers consider strongly. Their patients are not getting any healthier or less complex, and practitioners need to know how to give them the best care possible.

To see this full article, click here.

Skilled Nursing News

Article Six: Verma: CMS's Nursing Home Oversight Push More 'Internal' Amid PDPM Shift

Written by: Alex Spanko

The CMS administrator rolled out an ambitious four-part plan targeting the entire health care industry. In a recent speech she described a future where more consumer-focused information is incorporated into quality measures and reporting in a centralized submission system.

Seema Verma on Tuesday laid out a sweeping plan for data-driven oversight and enforcement across the health care spectrum, and took a similarly broad view of her agency's regulatory plans when directly asked about potential changes to the new Medicare payment model for nursing homes.

Specifically citing the early success of the agency's recent push to bolster nursing home oversight, the Centers for Medicare & Medicaid Services (CMS) administrator rolled out a four-part plan targeting the entire health care industry — centered around establishing clear performance benchmarks, boosting enforcement efforts, promoting transparency, and improving quality outcomes.

"Last year, we launched a framework for ensuring safety and quality in nursing homes," Verma said in a speech at the 2020 CMS Quality Conference in Baltimore. "This framework has shaped all of our work on nursing home quality, and in fact, was so successful that we decided to replicate it across the agency and in all our programs in 2020 and beyond."

That initiative has manifested itself in a variety of moves from CMS, from the introduction of a controversial warning icon for nursing homes with recent reports of abuse to a coming overhaul of the Nursing Home Compare website for consumers.

But when asked if the enforcement push will extend to the new Patient-Driven Payment Model (PDPM), Verma framed the CMS reform efforts as more inward-facing.

“That second one, around enforcement and oversight, I think is more internal, where we’re reorganizing so that we can do a better job of having oversight over nursing homes — and really, quite frankly, all health care facilities,” Verma said on a post-speech call with health care reporters, referring to the second of CMS’s four main points.

CMS’s reaction — or potential lack thereof — to changing provider behavior in the immediate wake of PDPM remains the largest open question about the new Medicare payment model.

With the first round of earnings reports from publicly traded skilled nursing facility operators and landlords nearly complete, the industry has almost unilaterally agreed that the change has been neutral to positive, with multiple reports of modest revenue increases.

CMS’s stated goal of budget neutrality for the new payment model has raised some concerns that the federal government may adjust rates downward in the future to compensate for the early gains, or even claw back some of the additional funding once it has a chance to fully vet the data.

But at least from the industry’s perspective, those fears remain unfounded.

“I actually don’t expect a clawback. I think CMS, despite some comments, expected some positive growth,” Sabra Health Care REIT (Nasdaq: SBRA) Rick Matros said during his company’s fourth-quarter 2019 earnings call earlier this week.

Speaking at the eCap health care summit in Florida last week, American Health Care Association CEO Mark Parkinson took things a step further by positing that there simply

isn't enough time for CMS to implement any sweeping PDPM changes this year — and that any adjustments would likely come in October 2021, the start of the federal government's 2022 fiscal year.

"I don't think that CMS has, or we have, enough information now to currently act," Parkinson said.

While Verma didn't delve into the specifics of CMS's pending PDPM plans, she emphasized on the call with reporters that the agency will continue to keep an eye on quality.

"As these new policies are implemented, it doesn't change our commitment to quality care for patients," she said. "It's a different payment system. But the assurance around quality and safety has not changed."

As CMS has in the past, Verma in her prepared remarks vowed to incorporate more consumer-focused information into its quality measures and reporting, while also using technology to more closely monitor operators. In particular, she described a future in which industry stakeholders and clinicians could send information to a single, centralized submission system, while government officials monitor clinical data and outcomes directly from operators' electronic health record (EHR) systems.

"Moving to a system where we're able to take quality data from the EHR, we can combine it with claims data, we can see what's going on in program integrity," Verma said on the call. "And we should be able to identify those high-quality providers on the front end, and then identify where we have weaknesses — I think, in a way, that's been fairly unprecedented."

In addition, CMS is working to streamline its expectations and quality measures across Medicare, Medicaid, and Medicare Advantage, Verma said during the discussion with reporters.

“We want to have one set of measures, so providers aren’t dealing with different measures,” she said.

In addition, Verma touted the success of the agency’s comprehensive nursing home reform plan in her speech, pointing to CMS’s efforts to standardize processes across the 10 regional offices that oversee state-level skilled nursing facility survey agencies.

“We are now using the same tools, conducting reviews in a more systematic and objective manner, and using data analytic tools to evaluate their performance,” she said in her prepared remarks. “We are also submitting cases with significant issues to a committee of CMS staff from across the nation to ensure that enforcement decisions [are] fair and consistent.”

To see this full article, click here.