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A desultory disaster: the near-term failure of US long-term care

A sad fate

The care of old, vulnerable and chronically ill people (long-term care) in the United States has been neglected for as long as there have been old, vulnerable, and chronically ill people in the United States. As part of the pioneer culture in the US, youth and robust adulthood are revered. Until 1965, if older folks were lucky to have caring and supportive families and friends who also had means, their situation was probably okay. If not, then it was miserable, and they probably didn't survive long.

It was so bad, for so long that the country was at a critical juncture, and the Social Security Amendments were passed after only 4 months of drafting. The model was to provide de-minimis government-sponsored coverage for professional residences (nursing homes) and domiciliary care (home care). This represented an enormous break from the prior social contract and spawned a huge bureaucracy (HHS).

How have we done as a country, as a society, since 1965? The care of the old, vulnerable, and chronically ill citizens in the United States is *still* neglected.

"Evidence," you say; "give me evidence!"

- United States spends 46% of the OECD average on long-term care while spending 246% of the OECD average on acute healthcare.
- Nursing homes are chronically underfunded, with 66% operating at a loss.
- About 77% of nursing homes were built between 1963 and 1970, which means that, if their mandatory retirement age were 65, they would be forced out of service. And there haven't been many new nursing homes built since the 1990s. Which raises the question: Would you stay at a Hilton or Marriott that was 60 years old?
- Home care, and community-based services are bewilderingly complex to access, and even when the consumer qualifies, applies, and can afford their portion of the costs, the agencies are often not able to appropriately staff to meet consumers' needs.


Irving L. Stackpole

Since 1965, with a few exceptions, coverage for long-term care in the US has continued to be neglected, and actual provision of care has deteriorated. We all know what's coming: the ineluctable surge in demand based on baby boom demographics.

At this point, the necessary physical infrastructure, programmatic coherence, and trained workforce does not exist to safely care for the old, vulnerable, and chronically ill people in the US. Will public sentiment today spur us into action, as happened in 1965? Unfortunately, I don't think so. Is there an implied social contract to provide long-term care? If there is, it's broken.

Several years ago, we wrote and spoke about the potential for change in LTC, suggesting that the US was at a "critical juncture." Such a point occurs when there's widespread agreement that the current state of affairs is unacceptable and that something new and substantially different is needed–a new social contract between society and government. Such a critical juncture occurred in 1965, with the passage of the Social Security Act

"Change will not come if we wait for some other person or some other time. We are the ones we've been waiting for. We are the change that we seek." – Barak Obama

How is this acceptable? There are lots of reasons how the US arrived at this point.

Generosity: A blessing or a curse?

The main enabler of the continued failure in long term care is the generosity of the American people; a tremendous amount of care for the old, vulnerable, and chronically ill is provided for free by families, relatives, and friends.

In 2023, the unpaid, frontline workforce include approximately 38 million people, and at around 36 billion hours, the value of the services was almost $600 billion. That's 45% more than the federal and state governments paid for nursing homes and home care combined. Is this a bad thing? Occasionally no, but in large measure, yes.

When families choose to nurture an old, vulnerable, or dying person, wonderful blessings often flow, which enrich the lives of manifold people within the family and in the greater community. Yet too often, this unpaid caring is the result of lack of access, or lack of money. In other words, too often families don't see that they have any other choice.

Some of the 36 billion unpaid hours are a drag on the emotional and financial well-being of US families. If only 25% of these hours were "relieved" by available, affordable care alternatives, 9 billion hours would then be released into the economy, which would be a 3.2% boost the nation's GDP.

The US long-term care market is facing significant challenges as it strives to meet the growing demand for services while grappling with persistent staffing shortages and evolving care models.

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At the New England Alliance's Winter Conference and Annual Meeting held in Woodstock, Vermont this past January, New England Administrator sat down with Mark Prifogle, the incoming ACHCA chair, to discuss future directions of the organization

New England Administrator: Please give a summary of your background.

Mark Prifogle: I currently serve as the vice president of operations - Indiana at BHI Senior Living, where I oversee comprehensive initiatives aimed at enhancing the quality of life for older adults. In addition, I'm a steering committee member of the Moving Forward Coalition, helping to shape strategic policy and champion innovative solutions for senior care. My leadership extends across numerous boards, including the ACHCA and Qsource, reflecting my commitment to advancing organizational excellence and community well-being.

My academic background includes a degree in psychology from Indiana University, and I am currently pursuing an MBA/PhD dual degree at the University of Cumbria to further strengthen my expertise in business strategy.

In addition to my executive roles, I have enjoyed serving as an adjunct professor at Manchester University, Purdue University, and Butler University. Through these positions, I've had the privilege of mentoring the next generation of healthcare leaders in experiential learning programs. My advisory work with McKesson, a Fortune 5 company, has broadened my perspective on the intersection of corporate strategy and senior living services.

Ultimately, I am driven by a deep-seated passion for delivering exceptional care, nurturing community collaboration, and leading transformative efforts that improve the lives of seniors and their families.

I first joined ACHCA as a member because of its reputation for nurturing leadership and professional growth in long-term care administration. Over the years, I served on multiple committees, participated in mentorship programs, and eventually joined the board of directors. My experiences with ACHCA have allowed me to connect with peers nationwide, share best practices, and advocate for the importance of well-informed, ethical leadership in senior care.

Now, as the incoming board chair, I am excited to continue this mission and help guide the organization through its next stage of growth.

NEA: Why are we returning to Myrtle Beach?

MP: A return to Myrtle Beach happened out of necessity, due to the timing of leaving our previous meeting planning group, Paramount, and transitioning to outsourced management. We had not selected a location for 2025 at our board meeting in Myrtle Beach last year, and we were advised that trying to do an RFP at that time was too short of a timeline. We were able to meet with the sales team at Myrtle Beach, while we were onsite, to book this year's convention. Rest assured, we have our meeting locations locked in for 2026 (Orlando) and 2027 (Las Vegas).

NEA: Why did ACHCA hire a management company?

MP: ACHCA recognized that an association management company (AMC), which specializes in managing associations and professional societies, could better meet its evolving needs than a small in-house staff. We had dwindled to 3.5 FTEs including the CEO. We were also inspired by NAB, which is managed by an AMC, Bostrom.

By partnering with an AMC, ACHCA gains access to specialized professionals who handle essential functions, such as event coordination, financial oversight, and membership outreach, with a level of expertise that would be costly or difficult to replicate internally. This arrangement also provides scalability, allowing ACHCA to smoothly adjust services as membership fluctuates or initiatives expand. Moreover, the AMC's shared infrastructure and pooled resources translate to significant cost savings, enabling ACHCA to invest more in its core mission, promoting ethical leadership and professional excellence in post-acute and long-term care administration, rather than in day-to-day administrative tasks.

NEA: How is that going?

MP: We have seen encouraging initial results, including:


Mark Prifogle

- Improved sales results. By having three salespeople on the team–membership development, vendor partnership development, and convention sponsorship exhibits–we have dedicated professionals to each of these areas of our business. For the first five months of our 2025 fiscal year, we have seen the first net increase in membership and vendor partnership enrollment in many, many years.
- Streamlined processes. Registration, billing, and event logistics have become more efficient, reducing friction points for both members and staff.
- Stronger foundation. By consolidating administrative tasks, our volunteer leaders and board can devote more energy to strategic initiatives and advocacy efforts rather than day-to-day operational tasks.

NEA: What changes are likely to result?

MP: Moving forward, members can expect:

- Enhanced educational programs, including more targeted webinars, updated online resources, and increased in-person training opportunities.
- Expanded membership benefits, such

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AI in senior living

Understanding the technology, managing risks, and responsible adoption

by Elizabeth Harris

ARTIFICIAL INTELLIGENCE HAS RAPIDLY BECOME AN INTEGRAL TOOL FOR SENIOR LIVING, from improving efficiency to enhancing resident care. For senior living professionals, it's essential to understand how AI models work, the risks they may present, and the best ways to responsibly implement them in your community. Within the realm of AI, there are two primary categories: generative AI and machine learning. Generative AI can create new content, such as text, images, or even music, while machine learning is focused on analyzing large sets of data to identify patterns and predict outcomes.

Senior living leadership may not realize it, but AI is likely already embedded in their facilities in ways they hadn't anticipated. Many of your existing vendors are already incorporating AI into their products, and it's important to know how to evaluate its use effectively. By the end of this essay, you'll leave with actionable insights that will enable you to responsibly navigate the world of AI and harness its full potential to benefit both your residents and your operations.

Five inherent risks of AI

As senior living organizations embrace AI technologies, it's essential to be aware of the inherent risks that come with them. The following five risks are central to responsible AI adoption:

1. Data risk: AI models rely heavily on data to function; if the integrity of the data is compromised or the data comes from unreliable sources, the output from the AI system can be flawed. For example, if the data used to train a model comes from outdated or inaccurate records, the decisions made by that model could be misleading, resulting in poor care or operational mistakes.
2. Model risk: AI models are designed to make predictions or decisions based on patterns identified in the data, but they can make mistakes. If the model has flaws, such as biases, inaccurate training data, or an insufficient understanding of individual circumstances, it could lead to suboptimal care decisions.
3. Ethical and practical risks: AI adoption raises several ethical issues, such as privacy concerns, bias, data ownership, and transparency. It's important to ensure that AI usage aligns with ethical standards, respects resident privacy, and adheres to legal and regulatory requirements.
4. Security risk: Cybersecurity threats are a significant concern when using AI in senior living environments. AI systems can be vulnerable to hacking, data breaches, and misuse, which could compromise resident data and expose the organization to financial and reputational damage.
5. Operational risk: AI adoption can also introduce operational challenges. In

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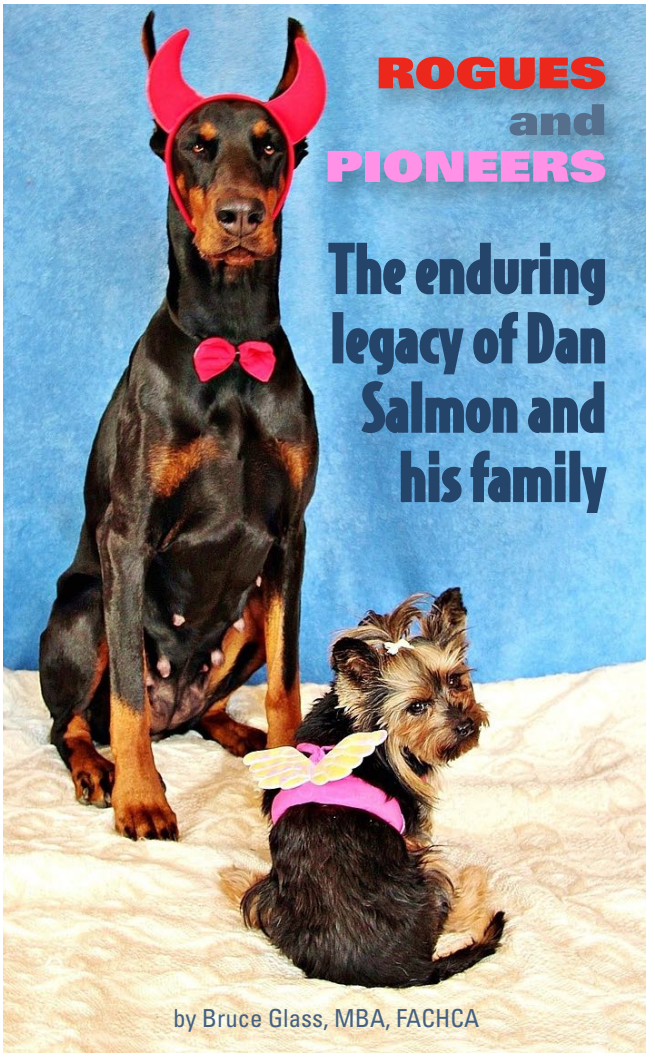


Families largely created New England's nursing home industry. At any meeting of CAHF, Mass Senior Care, or Maine Health Care, family owners dominated the offices.

That began to change in the 1980s with giants Hillhaven and Beverly buying up nursing homes throughout New England and the nation. Some survived into the 21st century, when the latest wave of out-of-town buyers began snapping up homes across the region. Today few survive, but one of the most prominent is Salmon Healthcare in Central Massachusetts.

And theirs is a tale of pioneering–and enduring quality.

The tale began in 1952, when Helen and Dan Salmon, Sr. bought a closed restaurant and converted it into a nursing home. Initially, the Salmon family lived upstairs in the same building, and the entire family helped in the operation. Dan recalls the true joy of emptying his first bed pan at age 10. Both senior Salmons were nurses, and young Danny was very involved, attending nursing school to hone his skills.

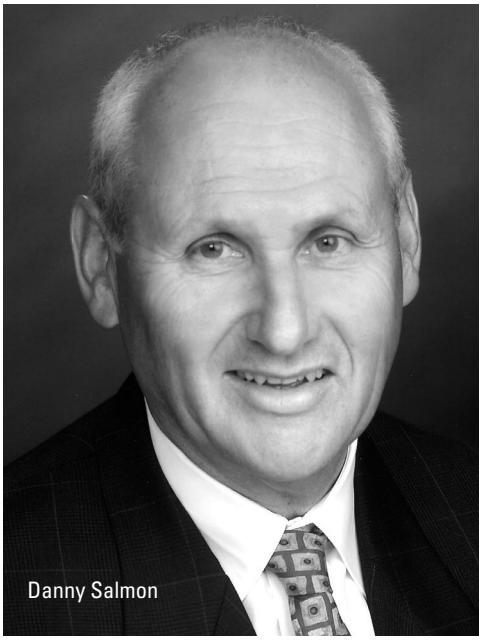
Initially nursing homes were entirely under the control of state and city governments. That changed in 1965 with the passage of Medicare and Medicaid, which greatly expanded the number of nursing homes. At this time the Salmon family opened a second nursing home, Beaumont at Northboro, and Dan Jr. took the reins from his parents. From that point on, Salmon Healthcare's growth trajectory was well under way.

As the organization expanded, it was faced with the same staff shortages that plagued the industry, even with the loyalty that good management generated. Using the policy, "Get a career, not a job", the Salmons built from within. All staff members were encouraged to advance: from laundry and housekeeping to CNA; from CNA to LPN; from LPN to RN. Salmon provided strong financial incentives and in-house programs to support the goal. According to Dan, "Whatever your position in a nursing home, you have the ability to make lives better."

Always a strong supporter of the industry, Dan was instrumental in the establishment of the Foundation of Mass. Senior Care. Despite pushback from many corporate organizations, the organization expanded on the Salmon concept of offering career opportunities for members' staff.

One of Dan's strong beliefs was that the standalone nursing home fell short of meeting seniors' needs. Therefore, Salmon Healthcare began to provide a full range of services–many on the same campus as the nursing homes. Whitney Place Assisted Living Centers were developed throughout Central Massachusetts. Along with this, Salmon opened one of the first in-house childcare centers, designed to assist single mothers on the staff.

Next came independent living, early learning centers, and home care–always with the mandate to provide a positive environment for residents, staff, families, and community. By the time Dan retired in 2000, the Salmon's reputation was well established. The next generation were in the wings, and under Phil LaCasse's skilled leadership, the organization continues to grow, never losing sight of the family's tradition. In 2014, Dan's son, Matt, became CEO, with his siblings, Kate and Andrew, assuming key positions.


Danny Salmon

Today, while the number of family-owned nursing homes and assisted living facilities has dropped dramatically, the third-generation, family-owned and -operated Salmon Health and Retirement continues the proud tradition of its founders.

Bill McGinley shares some thoughts about this issue's pioneer, Danny Salmon:

I worked for Danny Salmon from 1998 to 2015. I was the executive director of the Salmon Family Natick Campus which had both Whitney Place Assisted Living Residence and Beaumont Skilled Nursing and Rehabilitation Center.

After I had been on the job for a few weeks, Danny called me and asked if he could visit me and get to know me a little better. He came to the campus, and I gave him the grand tour. At one point, we rounded a corner on the nursing home, and I noticed that further down the hallway a CNA was sitting in a chair in the hallway next to a patient. My previous job was in more of a corporate environment and my first thought was "Oh, no, here is an employee sitting down on the job instead of working." Danny took one look at the scene and said to me, "Isn't that wonderful, that a CNA would take the time to sit down and spend time with a patient one-on-one?" That's how I knew that I was working for a family business and not a corporation. He had a totally different perspective than I did.

In over 40 years of business, dealing with hundreds of businesspeople, Danny Salmon was the only person who ever sent me an email signed, "Love, Danny."

Payment for and quality of Medicaid services

by K.R. Kaffenberger, PhD

In the fall of 2024, a group of researchers published their final report "Assessing Medicaid Payment Rates and Cost of Caring for the Medicaid Population in Nursing Homes". The report was prepared for DHHS by researchers and students from Miami University, RTI, and UMass Boston.

National studies on Medicaid costs and payments are unusual because each state can use different methods and rates. This makes payment analysis of Medicaid much more difficult than a federal program like Medicare in which differences in costs and payments are centrally collected and determined.

Despite the difficulty of the task, the researchers were able to collect and analyze data from 45 of the 50 states. Alaska data was collected and analyzed to some degree but was eventually excluded. The remaining 44 states still include most of the nation's freestanding Medicaid-certified nursing homes. The majority are licensed as skilled nursing facilities. The data used were from 2019, because the researchers did not wish to analyze data from the years of the pandemic. It led to unusual payments and circumstances in nursing facilities that would make it hard to generalize into the past or future.

For those of us who work with nursing facilities that accept Medicaid payments the headline finding is not surprising. On average, Medicaid pays $.82 for every $1.00 of cost of services.

There is significant variability among states on the methodologies used to determine costs and payments. Mathematical and statistical approaches were used to establish reasonable comparability in the study.

There are also differences between types of nursing homes by ownership. Some nursing facilities that have higher staffing levels are only being paid $.77 for $1.00 of services while facilities with lower staffing levels may be receiving $.85 for $1.00 of services. Another finding was that on average, all payer costs approximated all payer payments across all types of ownership types. Medicaid payment shortfalls were made up by overpayments from other sources. Individual states or facilities may not be at the average.

The report itself breaks down costs and payments by states, ownership types, and other parameters. This makes the report very useful for comparison of the various elements that are described in the extensive tables and other data representations. For instance, not-for-profits are more likely to have lower payment-to-cost ratios (they maintain more costs despite payment limitations), while facilities with a lower percentage of Medicaid residents often accept lower payment-to-cost ratios. Facilities that are part of a CCRC on average accept lower payment-to-cost ratios, but by most other parameters facilities are remarkably similar. Most facilities score payment-to-cost ratios between .80 and .83.

"Regardless, Medicaid payment rates are important determinants of nursing home quality, as past work has found that nursing homes that saw cuts in their Medicaid payment rates reduced staffing levels," according to the study.

Some advocates for nursing home quality have claimed that nursing homes have sometimes sacrificed quality to insure or elevate profits. The relationship between Medicaid payments and quality has not been determined in a careful (i.e. scientific) way. As the study says, it is unclear whether the reduced staffing levels associated with Medicaid payment cuts, "… is due to nursing homes attempting to maintain the same level of profitability or due to the lack of financial resources to pay staff."

"Medicaid payment rates are important determinants of nursing home quality."

Two senior members of the research team, Edward Alan Miller, Ph.D. and Marc A. Cohen, Ph.D., both of UMass Boston, announced a plan to participate in a study to relate Medicaid payment to cost ratios and quality. The Donaghue Foundation has provided grant funds to use the original study data to relate payment variability to quality outcomes. Are five-star quality ratings, fall rates, hospitalization rates, and other quality outcomes affected by changes in Medicaid payment rates?

Miller points out that if you're going to invest dollars for quality it's important to know what makes a difference. He says that the proposed research will only show association (statistical relatedness) not causation (one action causes another). It is hoped that future research, with data collected over a broader range of time, will be able find causation.

For now, the relationship between quality and profit may be the most pressing issue on observers' minds. Should some nursing homes be disparaged for guarding profit at the cost of quality?

But the larger issue of what changes will provide better quality, while related, may be somewhat different. Do different owner characteristics provide different outcomes with similar costs? Are some management approaches more successful than others? Do different staffing mixes provide different quality outcomes despite similar costs? Are some payor methods better than others? Cost is always a factor but there are other factors as well. The current study and following studies may tease out some answers that could make services more efficient and effective–in short, better.

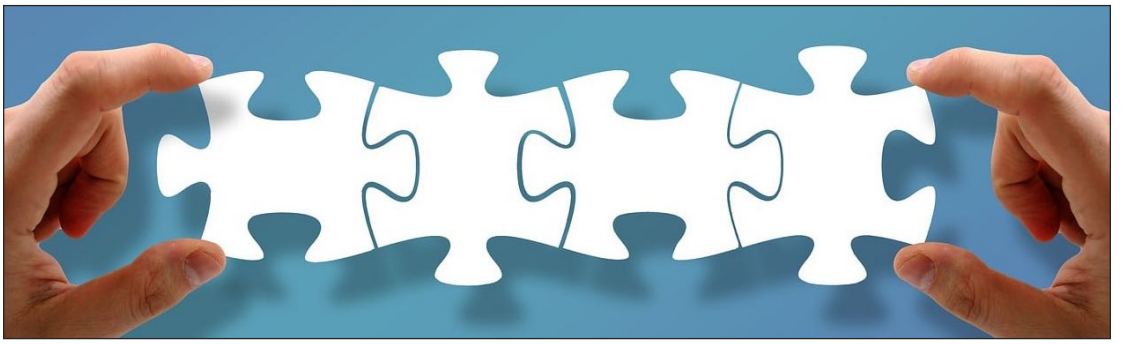
To find out more about pursuing fair payment for services by Medicaid, understanding where your state stands in the order of Medicaid payments, and the relationship between payor mix and quality, read the initial study.

KR Kaffenberger, Ph.D., M.P.H., is a fellow of the Gerontology Institute at UMass Boston and a former nursing home administrator.

FROM THE DISTRICT ONE DIRECTOR

Angela Perry, PhD, LNHA, FACHCA

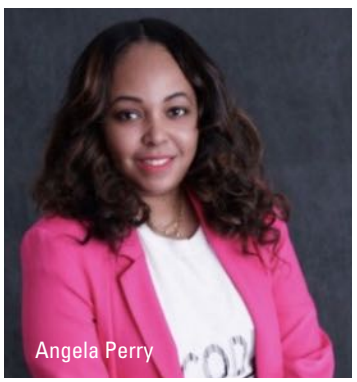
Get involved with ACHCA and consider becoming a Fellow



We are now entering the second season of 2025 and initiatives within the ACHCA. Member engagement on various levels is imperative to the cultivation of the "college." I am highlighting several services to encourage your participation to apply, contribute, and join throughout the year.

First, the BEST (Best Practices, Education, Strategies & Training) committee has replaced the Diversity, Equity, Inclusion, & Belonging committee's original namesake. The slogan is more representative of all areas to enhance the cultural experience of the vast demographics that embody the general membership. Our slogan is "BET on US!" Current initiatives include regular storytelling about nursing facilities or individual administrators that our membership represents through a spotlighted promotion. Specifically, the plan is to highlight and share best practices from the community that have led to creative and unique integration of sustainable diversity and positive operational outcomes.

Secondly, the quarterly newsletter is back in full swing. The goal is to provide practical tools that can be applied in any setting to build the workforce and enhance cohesiveness. Sharing metrics, highlighting cultural holidays or special events, and other resources will continue to be published for review.



Angela Perry

Thirdly, the BEST committee will be meeting regularly with the Member Experience committee. The focus will be to strategically align goals, resources, and execution of tasks to seek efficiency. Ultimately, member participation is important for the success of either committee to ensure we are meeting members' expectations and offering access to benefits that are meaningful.

Lastly, we are encouraging more members to apply to become an ACHCA Fellow, which is a distinguished level of recognition that approximately 400 members have achieved. It requires a record of active participation within the long-term care industry; suitable formal education, including degree designation, teaching, and/or continued education (CEUs); contributions to public awareness such as leading or participating in civic and community organizations, participating at ACHCA chapter or national events such as Convention, serving as a committee member, engaging in speaking engagements, or other noteworthy activities within the industry.

The benefits of becoming a Fellow are bountiful for many reasons. For instance, having the FACHCA distinction is recognizable and would set you apart from your peers. You could apply to be nominated for national board seats. Or, you could serve as a mentor to an emerging professional by partnering within the Mentor Program. Moreso, your commitment and dedication to the long-term care industry would be further confirmed through the recognition.

I encourage each of you to reevaluate your journey and apply to become a Fellow today. More information on the process can be found at the national ACHCA site. Any interest in the BEST and Member Experience committees can be directly communicated to yours truly: angelacodew@gmail.com.

"Mountains always look high until you reach the top!"

Musings and successful aging

by Sheldon Ornstein, Ed.D, RN, LNHA

THE TERM "MUSING" MEANS "TO BECOME ABSORBED IN THOUGHT." FOR SOME TIME NOW I'VE BEEN THINKING ABOUT THE MEANING OF THE WORD WITH ALL ITS NUANCES.

Over the past eight years I've been writing articles about aging. And for sixty years I've cared for countless sick and disabled elderly individuals in my capacity as a registered professional nurse.

My personal musings have recently led me to question whether I could achieve a long and healthy life by staying committed to a lifestyle that revolves around a healthy diet, a reasonable exercise regime, and, above all, avoiding unwanted emotional stress–as if that was at all possible. Hopefully my conviction and approach would get me through uncertain years ahead reasonably intact. I am not there yet, but I continue working on my path forward. As it is said, "time will tell."

Otherwise, with the passage of time, I've begun accepting the notion that living a healthy life doesn't necessarily guarantee a longer one. Unanticipated illnesses often arise without advance warnings.

I have many friends and longtime professional colleagues in my age group who were staunch marathon runners and bodybuilders. However, in their later years they have begun experiencing physical and disabling problems that have been, rightly or wrongly, associated with the aging process.

Was all this healthy living for naught? I've repeatedly asked myself, should my friends and colleagues have taken up less stressful sports like pickleball, golf, or even chess? And should I now begin questioning the value of the many years ingesting numerous vitamins with peculiar tongue twisting names, avoiding sugary beverages, limiting foods high in trans fats, and exhausting myself with endless daily exercise, as if it's the chosen path to a long and fruitful life?

The researcher Kastenbaum states, "The passage of time, as measured by the calendar, is a reliable index of change in our bodies and in limitations and abilities." If he is correct, then my belief for growing old is nothing more than an "unrelieved annoyance for checking off on a yearly calendar."

Consider the following questions and how you would answer them.

1. Can I control some of the known aging illnesses that have been diagnosed and documented by well-known geriatricians?
2. What is preventing me from reaching an elusive, healthy life free from many illnesses?
3. Can I do anything about what happens to my body as I continue growing old?
4. Must I resign myself to the aging phenomena that gerontologists refer to as a "physical impoverishment" along with endless visits to one doctor after another, looking for perhaps a permanent cure?
5. Can my body continue fending off one illness after another as I age?
6. Am I prepared to respond to emergencies before they incapacitate me?
7. Can I count on a sound mind in a reasonably sound body as I age?
8. Is poor health synonymous with growing old?

Time after time we falsely associate being ill with growing old. Do you agree? And if so, then apply the method of musing for your answer.

Rabbi Rachel Cowan, in her inspiring and informative book, "Wise Aging, Living with Joy, Resilience and Spirit," states, "How can aging be a good thing? Aging too often feels like drifting downhill to a place we don't want to go. But each year a door opens with opportunities, while others close with loss. Will we return towards these opportunities and find new joy and meaning in life?"

Consider opening the door to those new and exciting opportunities. They are there for the taking.

Here are several musings you might want to try on for size:

- How can we spend time? Research states that time is an irreplaceable source that must be spent wisely to be effective but can also be difficult to achieve without effort on the individual's part.
- How can we achieve the elusive happy life? Being with friends, family, and community for their social and spiritual value generates emotional satisfaction.
- Pursue gratefulness for those whom you love and respect.
- Be kind to your mind by vigorously pursuing kindness in word and deed with others, particularly for those who are less fortunate.
- Openly encourage others who seek your attention.

Here is a term to mull over: "viable happiness." Consider its relevance on how it can relate to you personally as you review the following:

- It occurs when you commit to principles for living a good life.
- It occurs when you consider practicing the mus-

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"Help! Help! Help!"

My introduction into long term care started with a tour of the nursing home I would eventually call home for the first two years of my career. We started the tour on the fifth floor, then took the stairs to the fourth floor, skipped the third, being assured it looked exactly like the fourth and the fifth and landed on the second floor. The second floor had recently been transformed from a long-term care unit to a short-term care unit. It was like walking into a completely different center, with bright lights, a restaurant style dining room, and a state-of-the-art rehabilitation center.

The first time I stepped foot on the third floor was a few weeks later, after going through the hiring process and two days of orientation, I began to make rounds. As promised, the third floor looked exactly like the fourth and fifth floors, with one small exception; the residents on the third floor needed a lot more attention. It was what they called the "skilled unit."

The center is shaped like a figure eight, with two elevators in the middle opening in front of the nurse's station. Semi-private resident rooms spread out on either side, with a dining area on one end and a sitting area on the other. I introduced myself to the nurse sitting behind the desk on my first visit. Her name was Donna, she was the unit manager and stood up to shake my hand and welcome me aboard. Then it happened.

"Help! Help! Help!" a woman cried out. Startled, I took a step backward and looked toward the sound. Donna didn't flinch.

"I'm right here," she called out. She checked her pockets and smiled at me as she walked around the nurse's station. "I'll be right back," she said. "Don't go anywhere." I nodded, tight lipped. Donna

knocked lightly on a partially opened door and went in. "I'm here. I'm here," she said.

A few minutes later, Donna came out and went to the kitchenette. She held up a finger, letting me know she needed another minute. I nodded. Inside the kitchenette she grabbed a small can of ginger ale, a straw, and an ice cream cone. She held them up for my view as she went back into the resident's room.

"That is Mrs. Andrews," she said, coming back to the nurse's station. "She's blind. She lost her eyesight due to complications from diabetes a few months ago." I exhaled loudly. She nodded. "I know. Scary." She went back behind the nurse's station and sat down.

Continued on next page

Ralph Peterson

Continued from preceding page

We spent the next 20 minutes or so talking, I told her all about me and my experience working at a military clinic, and she told me all about her and her experience working in long term care.

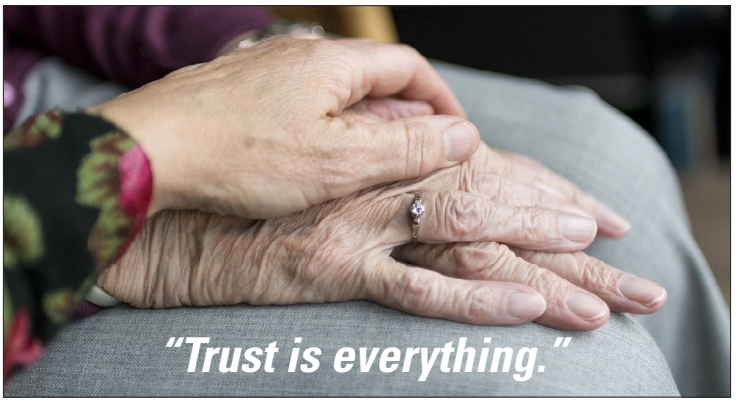
"People only come here for one reason," she said. "Do you know what it is?" I looked away, thinking about it and shrugged.

"Not really."

"A promise. That is why people come here. That is why family members bring their loved ones here. They want a promise that everything is going to be okay. A promise that they can trust us. A promise that they will be safe."

I nodded. "Wow. Right. Okay. That makes sense," I said.

"I want you to keep that in mind as you walk around and interact with some of the residents. Assure them that they are okay. Assure them that this is a safe place. Ask them if they need anything, and if they say yes, get it for them, or get one of us and we will get it for them." I nodded.



"Got it," I said.

This conversation occurred more than 20 years ago and continues to stand out as one of the most important things I ever learned while working in senior care: Trust is everything.

Recently, I attended a workshop led by Scott Carley. Scott is a management development coach who specializes in helping organizations create high-performing teams. In the workshop, he introduced the Trust Credit Score system, a tool for measuring a manager's trustworthiness within an organization. Like a financial credit score, the Trust Credit Score quantifies the relationship between management and staff, measuring trust as the critical factor in leadership. It cuts to the heart of the employee-manager relationship with one simple question: Can I trust you?

As always, I hope I made you think and smile.

Ralph Peterson of The Core Fourteen works with senior care organizations on leadership training, Quality Awards and QAPI.. To learn more call or text Ralph directly: (914) 656-0190

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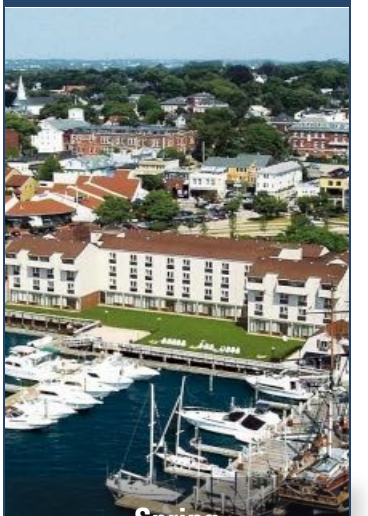

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Understanding AI

Continued from page 6

particular, reliance on third-party vendors for AI systems or data can introduce risks if those vendors experience breaches, delays, or failures in their own supply chains, which could further disrupt operations and affect the delivery of essential services to senior living residents.

Five steps to responsible AI adoption

1. Implement two key policies
   - Acceptable use policy: This policy should clearly define what AI tools and applications are permissible within the organization. It should outline:
     - Whether AI is permitted or prohibited in certain contexts, and a list of endorsed AI technologies
     - Approval processes for the use of AI, specifying who is authorized to approve its use, as well as who shares the responsibility for implementation and management
   - Security policy: A robust security policy is critical to protecting both resident data and organizational assets. This should outline how AI tools are to be secured, who is responsible for maintaining security protocols, and how breaches will be handled.
2. Procure a business subscription

   When selecting generative AI tools, senior living organizations should invest in business-grade subscriptions rather than free or consumer-grade applications. Business subscriptions typically come with enhanced security, customer support, and compliance features, which are vital for protecting sensitive resident data and maintaining regulatory compliance.
3. Choose the right application

   Depending on the specific needs of the organization and its residents, AI has various applications in senior living, including:
   - Wearables: devices that monitor residents' health metrics, such as heart rate, steps taken, and sleep patterns. These devices can help anticipate health issues and allow for timely intervention.
   - Predictive analytics: Using AI to analyze data trends and predict future outcomes, such as health deterioration, emergency incidents, or staffing requirements.
   - Medication management: AI systems can help ensure that residents receive the correct medications at the right times and even alert caregivers if a dose is missed.
4. Take stock of current usage

   Before implementing new AI solutions, senior living organizations should assess their current uses of technology. This includes evaluating the existing tools and systems in place, identifying potential areas for improvement, and determining how new AI technologies can be integrated.
5. Provide training and support

   Organizations should provide ongoing education to ensure employees understand how to use AI tools, interpret their results, and manage any issues that arise. Support mechanisms should also be in place to assist staff as they transition to a more AI-driven environment.

As AI continues to evolve, it offers opportunities for enhanced care and innovation. However, administrators must recognize the importance of educating themselves on its use and ensuring that its implementation is both secure and compliant with regulatory requirements. By understanding the risks and taking proactive measures to assess vendors and their AI offerings, senior living administrators can safeguard against potential problems while maximizing the benefits of AI.

With careful planning and due diligence, AI can become a valuable tool that enhances care, safety, and efficiency, leading to better outcomes for both residents and staff. Ultimately, embracing AI as part of a comprehensive approach to senior care is an investment in the future of senior living.

Elizabeth Harris is the Director of Marketing for Skilled Cyber, a cybersecurity and compliance firm that serves the senior living industry. She leads the company's educational initiatives delivering presentations, training sessions, and demonstrations on Artificial Intelligence and legislative updates, specifically tailored to healthcare professionals. With a focus on the intersection of technology and healthcare, her knowledge and insights help to drive innovation while making complex topics more accessible.

Ornstein on aging

Continued from page 12

ings I mentioned earlier.
- It occurs as you achieve sustainable happiness for yourself and others.
- It occurs whenever a favorable opportunity comes your way. (If it does, don't hesitate–grab it with both hands)

With every book I've read on aging and the numerous articles I've written on the field of aging, there is a word that stands out: longevity. It is a human urge to live a long life with clarity of mind. You may have already experienced the results of longevity and are enjoying its benefits (i.e.: a long and fruitful life).

According to research, happiness and longevity are synonymous with each other and can be understood as the confidence we project when facing difficult and complex issues that surround our daily lives.

In a recent newspaper article entitled "Character Building," the psychologist, Angela Duckworth, states, "Character formation is the building block for three types of strength and growth:

1. strength of the heart (i.e.: being kind, considerate, generous)
2. strength of the mind (i.e.: being curious, open-minded, having good judgment)
3. strength of the will (i.e.: self-control, determination, courage)."

Character building demands that we assume the task of improving the world. It is also a Hebrew term, *tikkun olam*, which means "repairing the world." Commit to repair the world. Even small steps add up. Learn to care for others. The common good should be a fundamental part of education.

A final musing: Character building is a precursor to what we always strive for– a long and just life. If it is achievable, then pursue it! Happy musings.

In 1959 Dr. Sheldon Ornstein received his nursing diploma from the Mills-Bellevue Schools of Nursing becoming a registered professional nurse. He continued to earn several degrees including a Post Masters Certificate in Gerontology from Yeshiva University in 1979 and a Doctor of Education in Nursing Organization from Columbia University in 1997. He began his clinical career as head nurse on a rehabilitation unit, and nurse educator providing in-service education and clinical instruction for Nursing students and colleagues alike. He taught at several colleges and was an adjunct professor at Hunter College. Over the course of a 50+ year career, he held the position of Director of Nursing Services in long term care facilities before retiring in September of 2010 as Distinguished Lecturer/Associate Professor in the Department of Nursing at Lehman College, CUNY in the Bronx.

Boost the Morale and Communication of Your Staff With These Workshops & Seminars:

• Stress Management, Burnout and Compassion Fatigue
We define the sources of stress, understand street responses and how to management techniques

• Assessing your conflict management style
We identify different five conflict management styles and the steps to use to resolve for workplace conflict.

• Dealing with Challenging Behaviors & Difficult Conversations
We identify the characteristics of challenging behaviors and effective responses to these behaviors.

• Positive Aging
We identify components of living well in our older adult years and hear interview clips from experts.

"Patricia's workshop on challenging behaviors & difficult conversations provided valuable strategies, tools and confidence to take action and achieve greater harmony & resolution, with individuals & discussions I had previously resisted."

Tameryn Campbell, President & CEO, Masonic Health System, Inc./The Overlook in Charton, MA

"I highly endorse Patricia Raskin as a presenter and faciliatator for education programs for any leadership team. Patricia acomplishes more in an hour than most corporate retreats do in two days!"

Richard Gamache, CEO Aldersbridge Communities

Patricia Raskin, M. Ed, is an award winning radio producer business owner and leader. She has recently presented webinars and onsite workshops for Aldersbridge Communities, Mass-ALA, RIALA, and the New England Alliance.

patricia@patriciaraskin.com

The Marketing Guru on imminent failure

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Pioneering loneliness

Further enabling the sad state of long-term care in the US is yet another manifestation of the pioneering spirit, which is the endurance of loneliness. We are culturally trained to accept and endure loneliness. While recent public health researchers clearly shows that loneliness is epidemic and contributes to a host of chronic and acute illnesses, age-qualified individuals in the US persist in preferring to live alone. In the research, this bias is very durable between and among genders, age groups, and income strata.

The Harvard Joint Center for Housing Studies has predicted that by 2050, 60% of the single-family residences in the United States will be occupied by an individual over 80 years of age living alone. While we might challenge the proportions, the point is that "aging in place" is looking pretty lonely. Why does this bias toward living alone endure? The first is that the alternatives appear to be abysmal. Second is that acceptable alternatives appear to be too expensive. In the US, when an industry wants to move a market, they explain to the consumers why. When Apple wants me to buy a new iPhone, I am flooded with good reasons.

What are my choices?

What has the seniors housing industry done to convince age-. Income-. and asset-qualified seniors that theirs is a reasonable alternative to growing progressively more lonely and isolated at home? Very little.

What the industry has done is make the labels, categories, and types more complicated and confusing. Researchers clearly shown that age-. Income-. and asset-qualified consumers cannot differentiate effectively between and among congregate independent living, age-qualified housing, assisted living, independent living with services, memory care, nursing care, etc. The result is that the average acceptance of seniors housing in the US is about 10% (a few metropolitan areas rise from 25% to 30%). This means that 10% of qualified seniors access or accept seniors housing options. One method of marketing strategic planning is a SWOT (strengths, weaknesses, opportunities, and threats) analysis. It aims to identify who the competition is, and determine on what dimensions the competition is stronger or weaker.

Here we have an entire industry competing against loneliness and can't win. Is that effective marketing?

Nursing homes

The supply of nursing home beds is contracting. Occupancy rates in 2020 fell dramatically from 85% to 68%, and while there has been some recovery, rates have only increased to 72% as of 2021. There is also margin pressure, with Medicare Part C (so-called Medicare Advantage) growing in market share, and putting the screws to SNFs. This drop in occupancy and margin pressure spell disaster, causing closures, and reduced admissions. By our estimates, 30% of the SNF operations are "zombies," unable to support themselves with a margin, and have little or no cash on hand. The proposed staffing mandates were to be the final nail, so to speak. Even if the Biden staffing mandates are removed, the underlying financial and workforce drags persist.

Assisted living and other housing options

In contrast to the skilled nursing inventory, virtually all the US inventory of assisted living was built after 1990. There are about one million residents in the country's assisted living residences. The sector continues to recover from the pandemic. Assisted living providers are not immune to the staffing challenges facing the broader long-term care industry, with 77% reporting worsening workforce supply problems.

In the rush to deploy assisted living, developers and operators selectively targeted the higher socioeconomic strata in each marketplace. This is how assisted living earned its reputation as being "too expensive for me." Despite its Cadillac position in the marketplace, assisted living is attracting older and sicker consumers, becoming the de facto waiting room for the nation's nursing homes. Few providers seem prepared for this ineluctable migration of high acuity residents.

Home care services

Demand for home health care is growing. Pioneering loneliness (see above) as well as demographic changes, technological advances, and shifts in healthcare delivery models are driving an increasing demand for home-based care services. Like other segments of the long-term care market, home care agencies face challenges in meeting this demand due to workforce shortages and regulatory pressures.

HCBS/LTSS

Home and community-based services (HCBS) or long-term supports and services (LTSS) have to be referenced as sources of fulfilling the care demand among age-, income-, and disability-qualified individuals. The mind-numbingly complex labels, as well as the even more complex procedures for accessing these services guarantees maldistribution; a significant proportion of the population that qualifies for, and should access HCBS/LTSS does not.

And there is no motivational alignment to correct this maldistribution. For example, most of these services are partially funded by the state, and most states are already crushed by their Medicaid budgets. Doctors, hospitals, nursing homes, and home care agencies are poorly informed about the services, and are unable or unwilling to "get smart" in order to serve as navigators for the qualified population. There are a handful of local case managers who, while very competent, must charge the consumer herself for the navigation services, which immediately disqualifies about 70% or more of the otherwise qualified population. The result is that, with few exceptions, utilization of these programs is below theoretical demand.

The state of the sector and ACHCA

The care of and support for the nation's old, vulnerable, and chronically ill people (long-term care) in the United States has been and remains neglected. The residential options and program supports that have been designed, built, and developed since 1965 are in disarray, grossly underfunded, and maldistributed. No political or social urgency to repair the infrastructure or rationalize the programs appears on the front page or on the horizon. This is a desultory disaster for those in need, their families, and society at large.

ACHCA lacks the scale to make a difference as a lobbying group, to impact public option, or to offer meaningful policy alternatives to HHS, CMS, or the states' Medicaid directors.

A rear-guard action seems the only reasonable strategic option. By this I mean:

- Consolidate or merge with as many of the LTC advocacy groups as possible.
- Deliver CEUs as efficiently and economically as possible.
- Harmonize messages, i.e., social, emotional, and epidemiological and economic costs.
- Sprinkle disaster stories across public-facing media.
- Design alternate models so that they're available and at-the-ready should the politicians recognize we're at a critical juncture.

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NEA sits down with Mark Prifogle

Continued from page 4

as strategic partnerships that deliver tangible value, a focus on advocacy for our profession, robust mentorship programs, and even potential collaborative research initiatives.

- Greater organizational visibility. With professional management ensuring cohesive branding and communication, ACHCA can expand its influence and attract more partners, sponsors, and prospective members.

NEA: How will these changes benefit members?

MP: Ultimately, members will find that ACHCA is even more responsive to their needs, especially in terms of continuing education, career development, and peer support. Administrative efficiency translates into:

- Additional events and networking. As operational tasks are streamlined, ACHCA can focus on high-value in-person and virtual events where members learn from each other.
- Enhanced advocacy. Freed from some administrative burdens, leadership can engage more actively in legislative or policy discussions that impact senior care.

NEA: What steps are being taken to ensure financial stability?

MP: ACHCA continues to sharpen its financial stewardship by:

- Diversifying revenue streams. While membership dues remain essential, we are expanding non-dues revenue through sponsorships, grants, and partnerships with allied organizations.
- Budget transparency. We are creating clearer financial reports and projections for the board and members, ensuring accountability for every dollar spent.
- Strategic investments. Funds are directed toward mission-critical initiatives, like professional development programs and technology updates, to yield long-term organizational sustainability.
- Renewed emphasis on fundraising. While we have always accepted donations to fund key programs through our academy, we will renew our focus on charitable giving. Blair Quasnitschka has done a wonderful job as academy chair and, with more support, will be able to generate greater philanthropy from our members to areas of interest.

NEA: How can we increase membership?

MP: Some of our strategies include:

- Targeted outreach. We will engage potential members in various LTC and senior care segments (assisted living, home health, hospice) and highlight how ACHCA aligns with their professional needs.
- Student engagement by partnering with universities and allied health programs to introduce ACHCA to emerging administrators. I have long believed AIT and student membership should be offered at no cost. I have a resolution for discussion at the next Board meeting to make this happen.
- Modernized marketing, such as leveraging social media, blog posts, and member testimonials to showcase tangible benefits, including continuing education credits, networking, and leadership development.

NEA: What steps can we take to strengthen chapters?

MP: Local and state chapters form the backbone of ACHCA, serving as primary touchpoints for administrators. We plan to:

- Share resources by providing chapters with templated event ideas, marketing materials, and financial guidance to reduce administrative burdens.
- Strengthen chapter leadership by offering leadership training and mentorship for chapter officers, including help with recruiting volunteers and running local programs.
- Encourage collaboration by promoting cross-chapter networking events and giving members more ways to connect, share best practices, and build collaborative relationships.

NEA: As a 501(c)(3), how can we still advocate for our profession?

MP: ACHCA remains committed to advocating for effective, ethical leadership in long-term care. While 501(c)(3) organizations must carefully navigate lobbying activities, we can:

- Educate policymakers by providing research, data, and expert testimony to help shape informed policy decisions.
- Empower members by giving them the tools to talk with legislators or participate in public forums–within the boundaries of nonprofit advocacy rules.
- Collaborate with allies. We can work with larger coalitions or trade groups, ensuring that the voice of healthcare administrators is heard without overstepping the legal restrictions placed on 501(c)(3) entities.
- Create a public affairs committee. I will hear discussion on my proposal for such a committee at our next board meeting in Myrtle Beach. This committee will be designed to gather relevant legislative actions, at the state and federal level, for ACHCA to provide comment, testimony, or position statements. This will be a priority for my time as chair. We must provide a voice to the administrator in these policy discussions to improve our current conditions, and fend off attempts to undermine our profession.

NEA: With many changes in ownership, few facilities are covering the cost of membership or attendance. What can we do to help?

MP: We understand budget constraints in this era of corporate ownership. Possible support steps include:

- Scholarships or stipends. We will explore scholarship funds or sponsor-backed stipends that help offset membership and conference costs for administrators, particularly those in under-resourced settings.
- Flexible payment plans for membership dues or event fees to reduce financial barriers.
- Highlight ROI by emphasizing how professional development, networking, and insights from ACHCA events can yield long-term operational savings and quality improvement in their facilities.

NEA: How can ACHCA be more transparent to membership regarding organizational structure?

MP: Transparency remains a priority. We plan to:

- Publish organizational charts that clearly outline the roles of the board, committees, and any management company partners. I was able to share the relevant roles and contact information in person at the District 1/NEA conference in January. The presentation, with the contact information, was also provided digitally to all attendees.

Continued on next page

Q&A with Prifogle

Continued from preceding page

- Regular reports will provide periodic updates (financial and operational) through our website, newsletters, and annual meetings, ensuring that members know where and how decisions are made.
- Open forums and Q&A sessions (virtually or in-person) where members can inquire directly about governance, finances, and strategic planning.

NEA: Will there be efforts to rebuild regional camaraderie as had been previously?

MP: Yes. We recognize how valuable those regional ties are, both personally and professionally. Initiatives include:

- District conferences. Smaller, more frequent gatherings to complement larger annual events, will allow administrators to meet face-to-face with peers in their immediate area.
- Multi chapter collaboration. We encourage chapters that share geographic or professional interests to combine resources for educational events, networking gatherings, and local advocacy efforts.
- Online regional communities. Virtual forums and discussion boards grouped by region would enable members to share local updates, legislation developments, and job opportunities.

NEA: It was with great difficulty that a two-year term of chair was accepted. Do you think a longer term would be beneficial to provide continuity?

MP: In many organizations, a longer term can offer continuity and allow a leader's initiatives to fully materialize. However, there are also benefits to periodic leadership turnover: new perspectives, fresh ideas, and broad engagement from the membership. If, during my two-year term, we find that critical goals remain incomplete or need more oversight, I would support revisiting term length. Ultimately, balancing stability with the infusion of new leadership is vital.

NEA: At one time there was talk of merger with ACHE or other organizations. What is the status?

MP: ACHCA respects and collaborates with groups like the American College of Healthcare Executives, American Health Care Association, and LeadingAge, but at this time, there are no active plan to merge. Our focus is on strengthening our own identity as the premier professional association for post–acute and long–term care administrators. We do, however, continue to look for ways to partner on educational programming, research, and advocacy where our missions align.

NEA: Why did a "convocation" become a "convention?"

MP: Historically, "convocation" emphasized a ceremonial gathering primarily for professional fellowship and the conferral of recognition or awards, and the term is largely used solely in academia. The term "convention" signals a broader scope–welcoming more attendees, offering more expansive educational sessions, exhibitions, and networking opportunities. We found that calling it a "convention" better reflects the growing range of activities that ACHCA offers at these events, from workshops and panel discussions to vendor expos showcasing innovative tools for LTC facilities. It also invites a more diverse group of attendees, potentially including allied professionals, policy experts, and industry stakeholders.

NEA: Can you share a meaningful quote?

MP: We live in an age where the post-acute and aging services administrator will lead our society into the future. Our expertise will be more critical to the lives of the average American, over the next 30 years, in ways that have never before been experienced. The stakes, and expectations, have never been higher. ACHCA will continue to be the catalyst and expand its reach, and voice, in ways never thought possible. Now, more than ever, the administrator needs to lean into ACHCA for support, education, and advocacy that will be needed in the years to come.

NEA: How about some closing thoughts?

MP: As the incoming board chair, I'm proud to be part of an organization with such a strong track record of advocating for ethical and effective leadership in senior care. This interview has highlighted the major initiatives and changes underway, but the most important takeaway is that ACHCA's success depends on the engagement and passion of its members. Together, we can strengthen our chapters and districts, elevate our profession, and ensure that every resident in a long-term care setting receives the highest quality of care and compassion.

If there is anything else you'd like to explore or clarify, I'm always available to continue the conversation. Thank you for the opportunity to share these insights.

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