

New England ADMINISTRATOR

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2022

"Always respect your superiors; if you have any."

-Mark Twain



Searching for staff

IN THIS ISSUE:

Barbara Doyle, a powerful voice for non-profits • The geriatric orphan and aging
The C.A.R.E.S. Expert • The Marketing Guru • Talking Dirty • The Legal Perspective



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THE C.A.R.E.S. EXPERT

Five-Star Staffing Domain: Nursing Acuity and Staffing Ratings

by Kris Mastrangelo,
OTR/L, MBA, LNHA

Jim Smerczynski,
Electrical Engineer

Every quarter, HHI is inundated with phone calls regarding the Five-Star Staffing Domain for the Nursing Home Compare 5 Star Quality Rating. Most of the inquiries are related to seeking help with:

Assessing if all employees are accurately coded and reflected in PBJ submission,

Determining how many hours are needed to attain a higher star rating, or

Creating a customized spreadsheet showing current and needed hours for each nursing category.

The first request is straightforward; however, the second two requests require the ability to understand the CMS conversion of acuity to staffing. Most of the inquiries land at the question: How does CMS calculate the Adjusted Nursing Hours Per Patient Day?

In other words, how does



CMS convert acuity into a needed staffing level? This calculation is anything but straightforward and it has taken HHI multiple years to find the correct formula used by CMS.

The concept is simple: expected staffing levels based on patient acuity. However, the calculation is sophisticated and, in figure 1, the block diagram illustrates the procedural steps necessary to establish the Nursing Staff Rating for a skilled nursing facility. There are two independent data paths that the Centers for Medicare & Medicaid Services (CMS) use to determine this rating:

1. Hours

The recorded staffing hours (r) for each of the nursing categories:

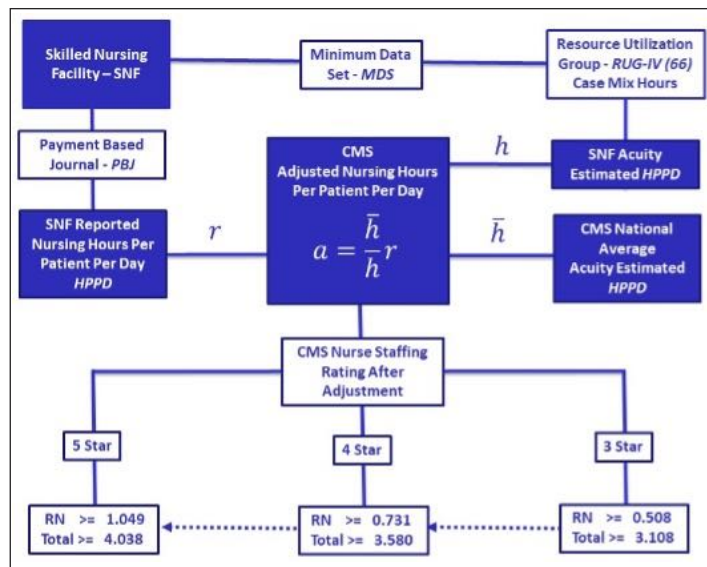


Figure 1 Five Star Nurse Staffing Rating Methodology



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Registered nurse (RN), Licensed practical nurse (LPN) and Certified nurse assistant (CNA) are reported quarterly through the Payroll-Based Journal (PBJ) data system.

The data when summarized leads to the aggregate hours per patient per day (HPPD) for each nursing types. The sum of the three nursing types provides the total HPPD.

2. Acuity

The second data source is the Resource Utilization Group – RUG-IV (66) that defines the daily payment rate and reimbursement for each patient. The staffing domain process utilizes the Minimum Data Set (MDS) to assess and classify each patient. If you ever wondered where this RUG level is located on the MDS, Specifically, Z0300, Insurance Billing.

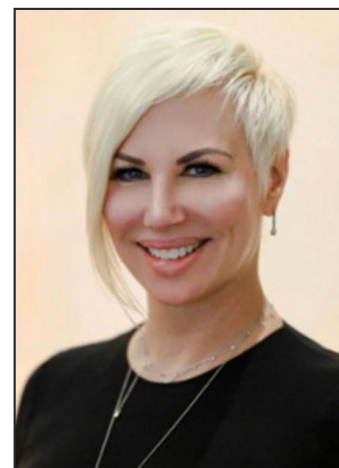
Definition of Variables for Figure 1

- a = Adjusted Nursing

Hours Per Patient Day

- h = SNF Acuity Estimated HPPD
- r = SNF Reported Nursing Hours Per Patient Per Day HPPD
- h = SNF Acuity Estimated HPPD
- h = CMS National Average Acuity Estimated HPPD

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Kris Mastrangelo

Long-term care staffing: the emergency

by Irving L. Stackpole, RRT, MEd



THE LONG-TERM CARE SEGMENT OF THE US HEALTHCARE SYSTEM IS IN THE MIDST OF THE WORST STAFFING CRISIS EVER.

This workforce contraction will continue to have negative consequences within the healthcare and social safety-net systems throughout the United States. The reasons for this debacle are well understood, but the real challenge is: What do we do now? The long-term care sector is in an emergency, struggling to survive.



Irving L. Stackpole

In the face of this dire situation, responsible managers and operators are being forced to do three things simultaneously—never an easy task.

First is day to day “scheduling for survival.” Juggling the demand for workers (frontline staff especially) with the available supply, trying to admit and/or care for patients, with a wary eye on the punitive regulatory consequences of errors is exhausting. This contraction in labor has resulted in a steep decline in SNF & HHA admissions and a raft of nursing home closures. This in turn is creating a backlog in hospitals and in the community, severely constraining what had been a barely functional system.

Second, managers must keep the employees they have. The historical supply of low-wage, frontline employees for nursing homes has dried up. No longer can turnover rates of over 50% be tolerated.

Third, managers must source and recruit employees in an environment with extremely low unemployment and COVID-19 related hesitancy in the workforce.

Phew!



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Let's start by stabilizing the patient. What W Edwards Deming would call a “controlable defect” is the unsustainable and extraordinarily high rates of frontline workforce turnover in long-term care.

Why they leave

Turnover rates among frontline workers in long-term care is 50 to 90% every year. The reasons healthcare workers leave their jobs are varied and have changed over time. These reasons can be parsed into these domains:

- Culture
- Compensation
- Career
- Relationships

Culture

The culture in any organization refers to “intersubjective reality,” or the unspoken rules that govern behavior and frame perceptions of, and attitudes toward the organization and the work. The culture in most long-term care environments sucks, frankly. Before you get

defensive, and say, “Not at my facility!” ask yourself if you know the name of the woman who works in the kitchen from 3 to 11, how many children she has, and the name of her beloved pet. Some of you do – congratulations. If you don't, you've made my point; keep reading.

Fortunately, there's a lot we can do to almost immediately build a better culture within our organizations. The single most important step is to ramp-up the communications, and specifically to listen. This can be done at many levels. Examples include but are not limited to management by walking around, where you actually stop, ask, and listen.

Interestingly recent research into MBWA finds that the behavior itself (management walking around) can often be seen as intrusive and unproductive by employees. Even if you're painfully shy, just showing up and listening changes

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The geriatric orphan and aging

by Sheldon Ornstein Ed.D, RN,
LNHA

The geriatric orphan is described as an elderly person with no close friends nor surviving family members who are available to provide emotional support. He or she has had significant others and lost them to death, distance, or fractured relationships. This individual has not, however, desired to be alone.

The researcher, Boyack, suggests, "It is imperative to establish a surrogate network, assist the individual through their grief, resolve any unfinished business and seek appropriate resources for maintenance in the community as long as desired and able." However for some, it can be a welcome relief to be among others in a congregate or institutional setting despite a commonly held belief against residing in a nursing facility or setting.

As we observe this individual we begin to understand the three Rs that define the tasks of aging as identified by the researcher, Cynthia Kelly. They are "accepting reality, fulfilling responsibility, and exercising rights."

- Reality has to do with accepting one's capacities in the health, social, and financial realms.
- Responsibility includes planning for one's survivors and for making the best choices regarding the remainder of life.
- Rights include exercising the right to move at one's own pace, the right to privacy, and the right to respect.

The geriatric orphan's plight is often compounded by the loneliness of living alone. Loneliness for all intent and purpose can be an amorphous

state of longing and feelings of isolation.

There is little information on the effects of living alone as it pertains to survival and satisfaction. Males who live alone or with someone other than a spouse are thought to be at a disadvantage in terms of survival, while it seems to make less difference to women. Both sexes are equally affected by income, race, physical activity and employment, but these are variable effects. The researcher Moustakas sees loneliness "as a condition of human life that sustains, extends and deepens humanity." In a recent research study on loneliness, it was claimed that "loneliness is evidence of the capacity to love. The degree of attachment is directly correlated with the felt loss when detachment occurs."

Florence Nightingale reflected on the fact that pets are an excellent companion for the elderly person who is living with a long term illness and with feelings of unrelenting loneliness. Studies concerning the value of a pet that lives with an isolated aged individual began appearing with popular literature around the 1980s. One reason for an old person to own a pet is com-

panionship and what that pet can bring to the relationship.

For those who care for an elder, here are several questions that can be asked that would aid in a clearer understanding and reason for that loneliness:

- Does the elderly individual reply when spoken to?





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- Does the elderly individual appear anxious, withdrawn, apathetic, or even hostile as demonstrated in the body language?
- Is he/she unable to articulate their personal needs?
- Is he/she eager for visitors but becomes distressed when they leave?

As a registered professional nurse who has worked and cared for the aged, I urge the caregivers of a geriatric orphan, whether at home or in a facility, to become familiar with a technique known as verbal intervention. Here are several suggested interventional approaches:

- Ask whether the patient feels lonely daily.
- Devote time with the individual by either sitting quietly or open with a mutually shared conversation.
- Inform the person when

PIONEERS & ROGUES: Barbara Doyle

We regularly feature a New England individual whose accomplishments—good or bad—helped to shape our profession.

A powerful voice for non-profits

In 1998, Massachusetts nursing homes were struggling with severe staffing shortages and changes in Medicare, as advocates attempted to require a Waiting List Law similar to that recently passed in Connecticut. With occupancy at 99% and hundreds of Medicaid patients backed up in hospitals, such a law would have had serious financial implications for the state's homes. As always, Medicaid rates were set well below cost of care.

The AHCA affiliate, MFNH (now Mass. Senior Care Association) was at the peak of its strength, representing over 500 facilities. Though primarily for proprietary homes, because of the industrywide concern for these issues, many non-profits abandoned the much smaller AMHA (now LeadingAgeMA), threatening its existence.

Faced with declining membership and limited ability to lobby, the AMHA board was under strong pressure to merge with the larger organization as a junior partner.

As the vote approached, one voice was adamant that the not-for-profit association must retain its independence. Barbara Doyle, president and CEO of Carleton-Willard Village, defied the odds to repel the threat.

Through her efforts, she convinced Elissa Sherman, the talented but reluctant young staffer to step in as the executive director. She then provided much of the moral, financial, and manpower support to assist Sherman in building LeadingAgeMA into the effective and respected voice for Massachusetts non-profits across the spectrum of senior care it is today.

Barbara served two terms as chair of the association, and went on to become an influential leader in the national organization as treasurer, while leading several important committees.

But it is her leadership of Carleton-Willard Village that has made her career so noteworthy.

Doyle was raised in Chicago and graduated from the University of Wisconsin at Madison, before moving to Boston, where her husband was attending Harvard Business School. She then enrolled in the senior care management program at Babson, and obtained licensure as a nursing home administrator in 1974.



Barbara Doyle

Serving as an administrator for nearly a decade with New England Deaconess prepared her for the career move that was to produce a remarkable record.

In 1975, the trustees of two venerable organizations, recognizing the changing needs of seniors, agreed to combine and develop a new concept in senior care. Five years later, the first elements of Carleton-Willard Village opened on a 65-acre parcel in Bedford, Massachusetts. The original construction included a 120-bed nursing home, 80 rest home beds, and 143 independent living units.

Barbara Doyle was recruited as the administrator of the nursing home.

Less than two years later, the trustees realized that the future success of the organization depended on strong leadership and dynamic vision, and Barbara was appointed president and CEO.

As a result, the organization continued to grow and prosper, adding services and upgrading both quality and physical plant. In 1988 CWV became the first accredited continuing care retirement community in Massachusetts, and one of the first in New England.

Today, at a time when the industry is under intense financial, regulatory, and staffing pressure, Carleton-Willard stands out, not only providing five-star nursing care, but outstanding quality of life for the 400 seniors at all levels who proudly call it home.

In the Ross-Worthen Garden on Campus is a plaque given by the Trustees of CWV that reads, "This garden honors Barbara A. Doyle, dedicated leader of Carleton-Willard and passionate advocate for the gracious care of elders."

We'd like a do-over, please

by Jeff Jerebker and Rick Gamache

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McKnight's Long Term Care News

If there was a way to go back to 1965 and have a do-over on nursing home design in America, we would not create or accept the institutional architecture, the chronic under-reimbursement and dysfunctional regulatory system that are hallmarks of our current reality. We suspect most stakeholders feel the same way.

With the tragedy of the COVID pandemic, we must ask ourselves why we can't unite to go forward with the painful lessons of the past. Why can't we drive home a better future for elders and younger disabled residents that need a more comprehensive level of care and support?

We need to reimagine the whole system of long-term care and the very culture that drives it. That includes physical nursing home design, how each person is cared for, the lack of living wages for direct caregivers, and the systems of regulation and reimbursement. The Live Oak Project was born in response to the catastrophe of COVID-driven nursing home deaths to boldly advocate for how and where we age.

We are not naive to the daunting challenges of this imperative vision. We are totally aware of the limits of the present system and the many stakeholder organizations, each with their own interests and investments. Does this mean we are doomed to, at best, marginal change that won't significantly reach down to the root of the problems of institutional environments, workforce inequities and shortages, and a culture of care whereby the provider, rather than the resident, is at its center?

Some blame nursing home ownership and management. Others lay fault on reimbursement, and some put the blame on regulations. The list goes on and on. The stark reality is that there is no scapegoat; there isn't a "good guy" versus a "bad guy."

The entirety of the system was poorly constructed on quicksand, bound to fail as soon as an earthquake happened. That occurred in 2020 with COVID-19. The system collapsed. The overcrowded, overregulated, under-reimbursed, institutionally designed

Continued on page 9

The seemingly insoluble staffing crisis

by Bruce Glass, MBA, FACHCA

Coming out of the pandemic, not all our workers have returned. Even more problematic, Rhode Island and other states have implemented minimum staffing requirements—with severe penalties for shortages. And, to make matters more desperate, President Biden has announced severe increases in both surveys and federal minimum staffing levels.

We try to present fresh topics with each issue of The New England Administrator, but staffing has become such a crisis that we've asked our experts to share thoughts and suggestions once again on how to deal with this seemingly insoluble problem. Hopefully, you will find some useful information, such as the inter-



esting initiative undertaken by New Hampshire.

We are all in this together, so I'm asking for help from anyone in the region who has found some success to share it with your colleagues. We always welcome relevant editorial content, but this topic is especially important.

Bruce Glass, MBA, FACHCA, is licensed for both nursing homes and assisted living in several New England states. He is currently principal of BruJan Management, an independent consulting firm. He can be reached at bruceglass@rocketmail.com.

Ornstein on the geriatric orphan

Continued from page 6

you will be available to talk again. However, keep your appointment as promised.

- Engage him/her with informal discussion pertaining to feelings, with the purpose of obtaining insight into what the individual is sensing.
- Don't expect an immediate response with that first intervention.
- When asking these questions, consider the emotional trauma they may cause.
- Never force a response brought on by a question which may cause anger.

Here is a final thought. Alice, an elderly nursing home resident once framed it in the following manner. "Loneliness is a devastating illness, more so than physical illness and can be fatal. Some people can

overcome a little, but the older the individual is, the more hazardous the loneliness becomes. A hug or touch is so important."

Here then is a quotable quote that succinctly expresses a healthier direction for those who live with the pain brought on by an emotional reaction.

"Hope never abandons you, you abandon it." Anon.

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.



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Redesigning nursing homes

Continued from page 7

nursing homes crumbled leaving many dead from the virus or from isolation, an overwhelmed workforce, etc.

What we've learned (and knew) about nursing home design

Every person is unique as is every nursing home community. Before us lies the opportunity to truly create a person-directed culture that reflects the richness of the people who live and work there.

We owe it to our elders, our care partners, and all other stakeholders, including investors, to feel the intrinsic rewards of an atmosphere where every individual can thrive.

The pandemic has taught us much, including that underfunding elder care is a policy decision that has contributed mightily to the low salaries of Direct Care Workers and has stifled innovation across the long-term care landscape.

To achieve the level of change necessary, all of us, including government regulators, policymakers, elders, consumers, advocates and providers, need to help shoulder the re-

sponsibility of fixing a system that was never properly designed.

There are a number of forward-thinking, progressive providers around the country that have already implemented successfully reimagined environments, cultures of care, organization and support of staff, and relationships with regulators. Let's bring that knowledge together and open our hearts and minds to creating a new system that works for the individuals who live and work in long-term care.

In a world where so much seems broken and dysfunctional, fixing long-term care suddenly seems less formidable, and could provide a template for healing other societal problems.



It has been said that the darkest hour is right before the dawn. The light shines on all of us to create a better future.

The Live Oak Project is a passionate group of experienced long-term care professionals and activists, bound together by the desire to reimagine, reinvent, and transform Long-Term Care Services and Supports.

Jeff Jerebker was the Founder and CEO of Pinon Management, former Treasurer of Pioneer Network, Co-Founder of the Live Oak Project, and Board Member of Kallimos Communities.

Rick Gamache is the CEO of Aldersbridge Communities, a RI-based not-for-profit provider of health care and housing for low-income elders. He is a member of the Live Oak Project Steering Group, and the former board chair of The Eden Alternative.



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"ONE MORE THING," I SAID, STOPPING KIM AT THE DOOR.

She looked back impatiently. "This is important," I said, giving her my most sincere look

"You always say that" she said, stepping back into the door. I laughed.

"I think my dad used to always say it to me when I was a kid. Every time he didn't think I was listening to him, which was most of the time, he would grab me by the shoulders and make me look him in the eye, so he knew I was listening."

"What are you talking about?" she asked, shaking her head.

"Room 223. Mrs. Murphy's room. She might be getting a roommate this afternoon. Will you stop by and make sure the room is ready?"

"Seriously," she said. "That's what's 'So important?'" She used air quotes for emphasis. I laughed again.

"Would you have listened to me if I didn't say it was important?" She shrugged.

"Probably not," she said and left.

Later that night, my brother Scott called to catch up and I asked if he remembered Dad always saying "This is important" to us kids when he wanted us to really listen to him. He laughed for a minute and then grew silent. Our father had passed nearly six years ago.

"Actually," he said. "I talked to Dad about that once."

"Oh, yeah?"

"Yeah. He said, maybe not so much when we were younger, but as we grew up, he found himself wanting to tell us things, important things, so that we didn't make the same mistakes that he did."

"Really," I said trying to recall all the times my dad had said, "This is important," to me. My brother went on.

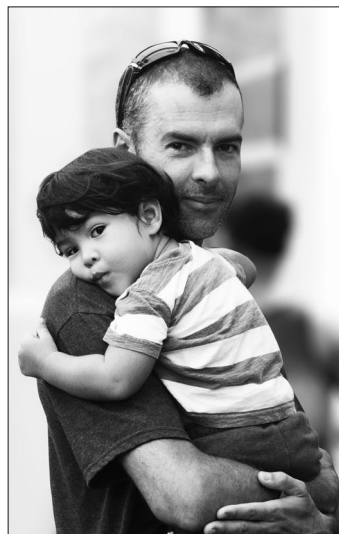
"He said, it wasn't until later in life that he realized his dad, our grandfather, did the same thing to him. And, like us, Dad said he didn't listen. Instead, he found himself making the same mistakes his dad had tried to warn him about."

"Wow," I said.

"Yeah," Scott said. "That's what I thought too."

The next morning, I was going over a monthly in-ser-

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NEWS FROM THE NATIONAL ORGANIZATION

ACHCA announces 2022 Election Results

The American College of Health Care Administrators (ACHCA) is pleased to announce the results of its 2022 election to fill positions on the ACHCA Board of Directors and Nominating Committee. The Nominating Committee accepted the election results on Friday, February 11, 2022. Results are based on a plurality of the votes cast by the voting membership.

Those elected to the ACHCA Board of Directors will be sworn in at the inaugural Board meeting in March and then begin their terms. The Nominating Committee thanks the members who submitted nominations and participated in the elections process. We welcome our new and returning Board members:

Sharon Eyster, CNHA, FACHCA, was re-elected to a three-year term to serve as an At Large Director on the Board of Directors. An active member for 15 years, Sharon has served on the Education and Nominating Committees, served as the Pennsylvania Chapter President from 2007-2014, and is currently serving as the Pennsylvania Chapter Treasurer since 2015. One of her goals during her term is planning for the future of our industry. "We need to ensure that ACHCA will continue to represent our profession today and for the future. Growing leadership within our industry is vital to our survival as an organization."

No stranger to the College nor the long-term care profession, Larry Slatky, CNHA, FACHCA, has been a licensed nursing home administrator since 1971. He has dedicated his life to the mission of the American College of Health Care Administrators, from holding committee positions,

including serving as National Chair (2006 – 2008), Chair of the Foundation, and Convocation. He notes that "the College once again is at a crossroad in identifying who we are, and I feel that my past experiences will assist in bringing the College once again to the forefront of the long term care industry. I do not take this opportunity lightly and want to assist in any way I can. By being in a decision making position for the College, it will allow me to provide needed expertise to the Board and membership."

Bonnie S. Wood, CNHA, FACHCA, previously served one three-year term as the District 5 Director on the Board of Directors (2016-2019). The District 5 Director serves Arizona, California, Colorado, Hawaii, Idaho, Kansas, Montana, Nebraska, Nevada, New Mexico, North Dakota, Northwest (AK, WA), Oklahoma, Oregon, South Dakota, Utah, and Wyoming. With a strong record of service on the National, Chapter, and Committee levels, Bonnie believes that her mission for professional development and growth as an Administrator can be served with this position. "In these challenging times, ACHCA needs strong leadership more than ever, [and] I welcome the opportunity to serve as District 5 Director."

Kendall Brune, Ph.D., FACHCA, and Kevin Hansen, Ph.D., FACHCA, were also elected to the board. Newly elected members to ACHCA's Nominating Committee include Mark Prifogle, FACHCA, Brian D. McBee, CNHA, CALA, FACHCA, and Robert (Bob) Armstrong, CNHA, Fellow Emeritus. Armstrong is a past president of the Maine ACHCA Chapter,

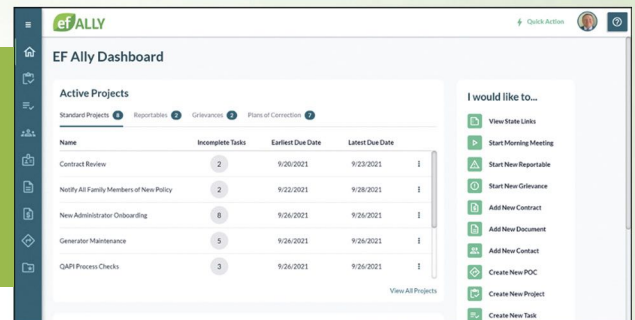


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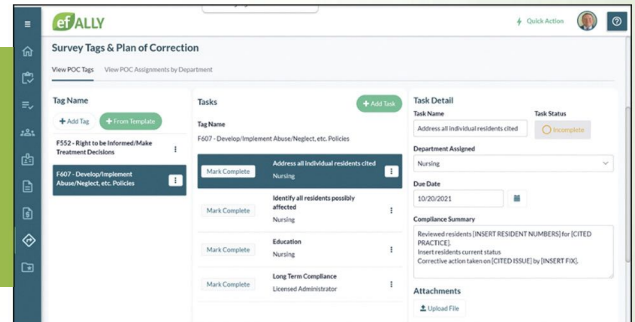


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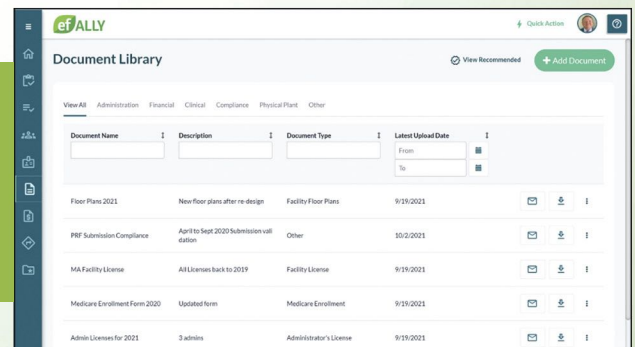


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Legislating the New Normal: COVID-19 Emergency Waivers and Permanent Changes to Long-Term Care

by **Jessa Boubker and
Lawrence W. Vernaglia**

On March 6, 2020, the Centers for Medicare and Medicaid (“CMS”) issued emergency blanket waivers (retroactive to March 1, 2020) for health care providers in response to the COVID-19 public health emergency (“PHE”). These blanket waivers, and subsequent guidance, provided significant flexibility for skilled nursing facilities (“SNFs”) and assisted living facilities (“ALFs”) to provide care and infection control measures in the midst of the PHE. Many states also issued their own waivers in response to the PHE in which the states supplemented the blanket waivers and provided state-specific flexibilities and guidance.

The waivers provided flexibility in key areas, such as removal of the 3-day hospitalization requirement to access Medicare SNF benefits, physician and non-physician in-person visit requirements, physician delegation of tasks requirements, and nursing staffing and qualification requirements. While some of the waivers were primarily focused on infection control measures, such as mask wearing policies, vaccination re-

quirements, and visitation policies, some of the waivers addressed the provision of more efficient, but less hands-on, care to address significant staffing shortages and limit the number of outside providers visiting a facility. In the face of continued staffing shortages and concerns regarding frequent use of off-site providers, some of these blanket waivers and

state-specific waivers could serve as examples for new legislation and regulations when the PHE ends.

Expanding Telehealth Access

The blanket waivers paved the way for the increased use of telehealth services inside SNFs and ALFs. Expanding telehealth (i.e. virtual health care) and digital health services can significantly increase access to care. Many residents in an SNF or ALF rely on outside health care providers. Telehealth services in the context of an SNF or ALF could mean an array of services:

1. Direct patient-physician interactions via remote communication modalities, such as conducting an appointment over the phone or through a computer,
2. Remote patient monitoring where a health care provider still visits a patient in-person but a physician delegates tasks and supervises the health care provider via remote communication modalities, or
3. Patient-centered digital health options, such as smartphone apps or wearable trackers that provide real-time data to a health care provider.

The ability to conduct a visit remotely or delegate tasks to health care providers already on-site via remote patient monitoring can significantly increase the efficiency and availability of care for SNF and ALF residents.

Increasing access to these telehealth services requires continued support from CMS and individual states. In addition to legislative or regulatory changes to expand telehealth options, however, SNFs and ALFs will need to make structural changes to adapt to offering these services. For example, an ALF should provide assistance in operating the technology, provide high-speed internet, or provide access to computers or tablets. Even then, telehealth services will not always be the right choice for every resident and their unique needs. For example, some residents cannot meaningfully interact with a tablet or computer, even if the practitioner on the other end is skilled at working with seniors. Having the option to provide these services, however, provides flexibility for providers and residents to be able to make care needs that are in the best interest of the resident.



Providing Basic Health Services in Assisted Living Facilities

The increased focus on telehealth services is only one example of the proposed solutions to provide continuity of care when the PHE ends. During COVID-19, reducing the number of outside visitors visiting SNFs and ALFs was imperative for infection control. In response, many states began allowing on-site health care providers to provide more complex services to ALF residents.

In Massachusetts for example, the Massachusetts Department of Public Health issued a waiver allowing non-Medication Administration Program Certified Staff “to administer rescue inhalers, epinephrine auto injectors and oxygen” to individuals in ALFs. Before the waiver, ALF staff in Massachusetts, including licensed nurses, were not permitted to provide nursing services, including basic health services (i.e., wound care and changing simple non-sterile dressings, administering injections like insulin, managing oxygen, or applying ointments or drops), to ALF residents. Family members would instead visit the resident to provide these basic services, or hire an outside health care provider to come deliver the care.

A current bill in the Massachusetts state legislature, called “an Act authorizing common sense health services in assisted living,” attempts to codify these waivers to allow ALFs to continue to provide certain basic health services after the PHE waivers end. Rhode Island, New Hampshire, and Maine have already enacted similar statutes

Continued on next page



Jessa Boubker



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Talking Dirty

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vice with my staff when a couple of people started a side conversation.

"Hey," I said getting their attention. "This is important." A couple of people laughed, which made me laugh. I looked around the room, shaking my head. I had a smile on my face.

"I say that all the time, don't I?" Everyone laughed and nodded.

Kim said, "You know you do," and everyone, including me, laughed a bit harder.

"Do you know why I always say, 'This is important?'" I waved the sheet of paper in the air but didn't wait for them to answer. Instead, I told them about my dad.

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

Ralph Peterson is a three-time best-selling author and a leading expert in management development in the long-term care industry. Ralph@ralphpeterson.com

The Legal Perspective

Continued from preceding page

and regulations before the PHE. Each of these states vary in the level of services an ALF may provide; for example, Rhode Island allows ALFs to provide a broader range of services than what the Massachusetts act would allow, including ulcer care, ostomy care, and catheter care.

Legislation and regulations such as these support an "aging in place" model of care. The "aging in place" model of care provides supports for residents to "age-up" in an ALF before moving on to higher levels of care when 24/7 skilled nursing services are required. New Jersey has fully adopted the "aging in place" model and has enacted regulations requiring ALFs to provide aging-up services. PHE waiver flexibilities have highlighted the ability for ALFs to provide this level of care and could serve as an example for continuing this care post-PHE.

What's Next?

While these waivers have proven beneficial to provide care to residents in SNFs and ALFs, and may prove beneficial in guiding future legislation and regulatory efforts, the quality of care and safety of residents remains the top priority.

As long-term care facilities have had to adjust their operations and oversight during the PHE, CMS has signaled its intent to evaluate how these changes have affected residents' health and safety. Notably, CMS has directed State Survey Agencies to focus on assessing the quality of care of nursing homes in its recertification surveys. A possible unintended benefit of the PHE waivers could be that they have generated real-world data illustrating that SNFs and ALFs can adopt certain practices, such as offering telehealth and basic health services, while still maintaining (or possibly improving) the quality of care for its residents.

This article encourages policy makers to consider taking steps to retain some of the waivers that have proven successful and beneficial post-PHE. Administrators and managers in long term care facilities, however, need to be planning today for the waivers to end with the PHE. The Biden Administration has advised the provider community that it will give at least a 60-day notice before deciding to not renew the PHE. Providers are advised to have a current inventory of the waivers on which the facility is relying and have a strategy to return to the operations in a non-waived environment.

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Lastly, figure 2 (below) portrays a user-friendly, one-page, Nurse Staffing Rating Chart for providers to calculate their Staffing Domain rating with knowledge of the:

- RN HPPD
- Total Nursing HPPD



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The Marketing Guru on the staffing crisis

Continued from page 4

the culture for the better. Another important way we listen (or don't) is through surveys. Whether simple or elaborate, asking employees and then utilizing their feedback helps to build trust and demonstrates that management believes, and that what is being said to you is important.

Compensation

Various representatives of long-term care industry keep telling the media and speaking out about the poor rates of pay for frontline workers. They are pleading for higher payments from Medicaid. The history of minimum wage compensation in long-term care, however, goes hand-in-glove with a history of poor work environments and the treatment of frontline workers as fungible, replaceable means to an end. The continuous refrain, "Give us more!" creates the wrong message, publicly and politically. The "victimhood" created by this message within our organizational cultures has a negative result.

The reality among the long-term care workforce is that most of them are asset limited, income constrained, and employed (ALICE)—often in two jobs. A recent article by KHN, an affiliate of Kaiser Health News,

described the situation in Kentucky/Ohio where Amazon was attracting low-wage, long-term care workers with compelling offers of much higher pay and better benefits. An organization like Amazon can pass inflationary costs on to consumers; long-term care providers cannot. Why would an employee stay working in a nursing home or home health agency when she can earn \$2.00 or even \$5.00 more per hour? Some will, and it would be extraordinarily valuable for us to learn why. How can we do that? By asking and then listening.

Career

Employment in long-term care has often been seen as a transitory or segue kind of job. The local nursing home is convenient, offers employment in a variety of shifts, and has a very low skills threshold. Some of the low-wage jobs in nursing centers will always be filled with these employees; however, in the current employment environment these individuals often get higher pay raises and better benefits. So, there are many employees in our organiza-

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Marketing Guru

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tions who will depart after some time with us to move on in their lives and their careers. This type of turnover is expected and can be planned.

Relationships

Too often, healthcare workers quit because of their poor relationships with their supervisors, or the lack of relationships among their coworkers. This is an empirical fact based on years of research. It is a particularly costly oversight among long-term care managers and operators. Having friends at work, feeling that people listen to you, and knowing that someone at work cares about you are "soft" employment dimensions with undeniably hard results. When these three dimensions are rated poorly, turnover is higher.

Why they stay

As was said above, workers too often quit because of poor relationships with their supervisors and their coworkers. But the inverse is also true; frontline workers stay in jobs despite better opportunities elsewhere because of the relationships that they have built,

or which have been nurtured around them. This evidence is equally compelling.

Frontline workers in health-care and in long-term care will forgo potential raises and other compensatory benefits because of relationships. Managers and operators can leverage this fact by not only encouraging supervisors and coworkers to build and maintain supportive, comfortable relationships, but also by measuring supervisors and managers based on their effectiveness at nurturing relationships. Remember, "What gets measured gets done."

Why they take these jobs

Recruiters have had a very profitable two years. The demand for frontline nursing staff, in particular, has been extraordinarily high, and agencies and recruiters have stepped into this surge in demand with gusto.

Our research on why frontline workers in long-term care take jobs shows that access, convenience, flexibility, and a personal referral as the most important factors. Each of these has many possible dimensions to leverage, but at a time when recruitment of frontline workers is so difficult, it is surprising to see how operators and managers do not take advantage of these facts. For example, access and convenience include physical location and public transportation. This would call for promotions and advertising in the neighborhood, on the bus lines and in the stores frequented by our target demographic.

Another glaring omission by managers and operators among the recruitment activities is the tokenism of the employee referral programs. Remember that a personal referral was identified as an important reason why many frontline long-term care workers were originally interested in and ultimately accepted the job. So having an employee referral program in your organization, especially in the current



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recruitment environment is critical. We know that to be successful, the "program" must not be static, but must be varied over time and with different incentives for the referring employee. The variety and variation of the incentives are more important than the size or value. This suggestion is not a "referral bonus," but a referral incentive. A fixed or flat amount per referred and hired employee turns your staff into headhunters—not relationship builders.

Will the patient survive the ER?

Given the macro and micro

economic factors, the political forces at work with the primary intermediary (CMS) and the overarching, indelible negative metaphor within long-term care, especially nursing homes, many will not make it out of the ER. My hope is that intelligent managers and operators will use the best, evidence-based insights to endure through what will be a difficult period of resuscitation and rehabilitation.

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