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ADMINISTRATOR

December
2022

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-Mark Twain

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The C.A.R.E.S. Expert • The Marketing Guru • Pioneers and Rogues • Talking Dirty

Harmony Healthcare INTERNATIONAL

GSA Harmony Healthcare International, Inc. (HHI)
Contract # 47QRAA22D00BZ

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Capability Statement

HHI C.A.R.E.S. Platform

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QAPI Program Development and Oversight
Response, Reporting and Prevention Guidance
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Analysis

CASPER Report Analysis
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Compliance Analysis (Off-Site)
Five-Star Quality Rating System Analysis
Medicaid Revenue and Risk Analysis
Medicare Part A PDPM Revenue and Risk Analysis
Medicare Part B Revenue and Risk Analysis
PEPPER Revenue and Risk Analysis
Quality Measures Analysis
Staffing Analysis

Corporate Overview

Harmony Healthcare International, Inc. (HHI) founded in 2001, is a Woman-Owned Small Business (WOSB) certified by the National Women Business Owners Corporation (NWBOC). Headquartered in Boston, MA, Harmony Healthcare International, Inc. (HHI) services Skilled Nursing Facilities and other health organizations in the area of Compliance, Analysis, Audit, Regulatory, Rehabilitation, Reimbursement, Education, Efficiency and Survey.

The HHI Team is composed of on staff, accomplished professionals who serve as HHI Consultants to for-profit, not-for-profit, stand-alone and multi-facility chains across the country. Historically, Harmony Healthcare International, Inc. (HHI) has ranked among the top 5,000 fastest-growing private companies in the U.S. for three consecutive years by Inc. Magazine.

Harmony Healthcare International, Inc. (HHI) is one of the nation's leading healthcare consulting companies, helping thousands of nursing facilities and healthcare organizations, from Northern Maine to Hawaii, with providing guidance, implementing systems and assisting with oversight to ensure residents and patients receive person-centered care. All the while, safeguarding that these clients receive the support they need to stay in business.

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Speaking Engagements

Kris is a nationally recognized keynote speaker in the Post Acute and Long Term Care (PALTC) continuum specializing in nursing homes, with more than 28 years of experience in the Health Care industry. Kris began as an Occupational Therapist with a degree from Tufts University followed by a Master's in Business Administration from Salem State University coupled with a Nursing Home Administrator's License. All of which afford Kris an in-depth perspective into the clinical, financial, and operational components critical for business success. Kris works collaboratively with industry experts to create continuing education and professional development courses for clinical professionals including Occupational Therapists, Physical Therapists, Speech Language Pathologists, Nurses, and Nursing Home Administrators.

National Affiliations

AHCA American Health Care Association
NCAL National Center for Assisted Living
ACHCA American College of Health Care Administrators
NASL National Association for the Support of Long Term Care
National Association of State Veterans Homes
LeadingAge™
NADONA National Association of Directors of Nursing Administration in LTC

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ANA American Nurses Association
ANCC American Nurses Credentialing Center

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Billing and Coding On-Site Mentoring
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Five-Star Quality Rating Audits and Improvement Methods
Home Care
Integrity (Therapy, MDS, etc.) Auditing and Monitoring
Managed Care Auditing and Monitoring
Managed Medicare Auditing and Monitoring
MDS Systems Assessment
Medicaid (Case Mix States) Auditing and Monitoring
Medicare Auditing and Monitoring
Medicare Part A Auditing and Monitoring
Medicare Part B Auditing and Monitoring
Mock MDS Focused Survey (Two Days)
Mock RAC (Recovery Audit Contractor) (Two Day)
Mock RAC (Recovery Audit Contractor) Therapy and MDS
Mock Regulatory Survey (Three Days)
Mock Survey Level IV
Mock Zone Program Integrity Contractor (ZPIC)
QAPI
Quality Measure Auditing and Monitoring
Skilled Therapy Documentation Review Auditing and Monitoring
Therapy Systems Assessment Auditing and Monitoring

Regulatory

Clinical Consulting (Wounds, Incontinence, Falls, Restraints, Quality Measures, etc.)
MDS Accuracy
MDS Completion
MDS Transmission
Plan of Care Monitoring
Policies and Procedures

Rehabilitation

Clinical, Financial and Operational Consulting
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Therapy Staffing

Reimbursement

Accountable Care Organization
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Consolidated Billing
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Five Star Quality Rating System
IDR (Informal Dispute Resolution)
IIDR (Independent Informal Dispute Resolution)
Infection Control
Mock Dementia Focused Survey (Two Days)
Mock MDS Focused Survey (Two Days – Five Days)
Mock Regulatory Survey
Plan of Correction Development
Policy and Procedure Review and Development

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

Are the RUGS being pulled out from under you?

State Medicaid RUGS options change to PDPM

by Kris Mastrangelo, OTR/L, MBA, LNHA

Today, there are approximately 36 states that use the MDS as a tool to determine Medicaid State Payment levels. In these states, the MDS uses a RUG-III or RUG-IV Case Mix methodology to calculate the reimbursement for state-specific Medicaid payment rates. Each state has flexibility to modify payment levels and RUG classification criterion in consideration of state specific nuances, i.e., customization of rates for Ventilator, BMI, TBI, etc. on the reimbursement payment levels.

On October 1, 2019, the Federal Payment system (not to be confused with state Medicaid levels) for Medicare Part A reimbursement levels, replaced the RUGS-IV 66 Case Mix methodology with a new Case Mix methodology, Patient Driven Payment Model (PDPM). The PDPM system has five components: PT/OT, SLP, nursing, and CMI. The nursing component mimics the RUGS-IV 66 model sans rehab levels (RU, RV, RH, RM, RL). So, in essence, the RUGS model is still present but baked into the nursing component of the PDPM model. Do not be fooled into thinking that the RUGs system is gone because it is technically alive and well calculating the nurse component under the veil of PDPM.

Because CMS will be removing several MDS data elements used in RUG-III and RUG-IV Case Mix methodology, these elements will no longer be required for federal purposes and the RUG-III and RUG-IV will technically no longer be functional.

One of the intentions of converting to a PDPM system for the Federal Medicare Part A payment levels is to utilize a streamlined assessment schedule versus a paper-intense RUG-III and RUG-IV Case Mix methodology by eliminating the tedious 14-day, 30-day, 60-day, 90-day, and OMRA assessments while keeping the 5-day assessments.

Seeing that the MDS is used for both State Medicaid Case Mix payment system and the Federal Medicare Part A payment system, the removal of the RUG-III and RUG-IV Case Mix methodology forces the State Medicaid Case Mix payment system to transition to a Medicaid PDPM payment system. This transition was originally scheduled for October 1, 2020 but delayed (due to COVID-19) until October 1, 2023 when CMS will no longer support RUG-III and RUG-IV case-mix methodologies via the Minimum Data Set (MDS). CMS is allowing a two-year grace period for Medicaid state providers to transition to PDPM versus RUG-III and RUG-IV Case Mix methodology until no later than October 1, 2025.

For states that want to continue to use RUG-III or RUG-IV assessments for calculating their State Medicaid Case Mix payment Case Mix groups

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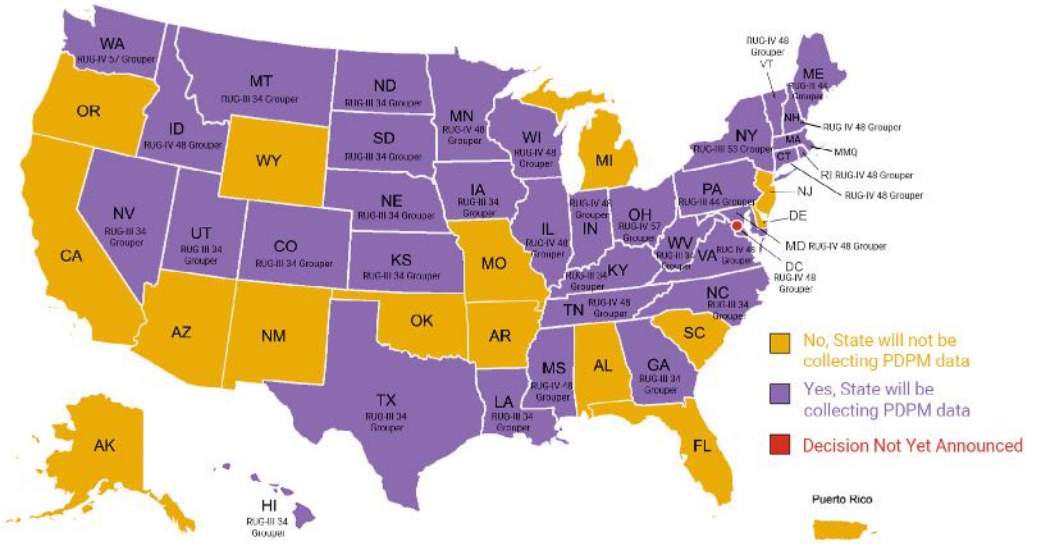
Kris Mastrangelo



PDPM conversion MDS collection OBRA assessments

Hiding in Plain Sight

Generational staffing crisis

by Irving L. Stackpole, RRT, MEd

The current staffing crisis in long-term care has been looming for decades and has generally been ignored. The underlying problem is demographics, and the current crisis, while precipitated by the COVID-19 pandemic, cannot be easily resolved. When the sector learns to leverage altruism, as well as make scheduling flexible and the culture acceptable, the crisis may be mitigated, but not–repeat not–eliminated.

The underlying problems are demographics, immigration, and culture.

Demographics

Born between 1985 in 2004 and by far the largest generation in American history, GenY, or "millennials," are currently between 18 and 37 years of age. For nursing homes and long-term care providers, this is the target market for recruitment.

Irving L. Stackpole

Gen Y has attracted attention from marketers because there are so many of them (79.5 million native born plus 7.1 million immigrants). Gen Y came of age with the War on Terrorism, the Great Recession, climate change, and the greatest disruptions and communication technologies in the history of the species. These millennials live and breathe high-tech, and they spend far more time interacting with gadgets than with anything else.

For these high-tech navigators, job placement ads in newspapers belong in reliquaries. The oldest of the millennials have been in the workforce for about 10 years, and they don't like it; they don't appreciate the work ethic they see with Baby Boomers and Gen X and may never fully adapt to the 40-hour workweek as we know it. Part of the reason for this is that the current Baby Boomers and Gen X have made economic life for Gen Y difficult. The economy in the United States has been through a time of flatline wage growth, while housing costs in particular have soared. Student loan debt exceeds credit card debt. This is the first generation in American history to believe that their prospects are less sanguine than their parents.

To make matters worse, Baby Boomers and Gen Xers hang around the proverbial water cooler, nostalgic for the "good old days" when they did "whatever it took" to get the job done. This is destructive.

US Generations			
	From	To	Current n (millions)
GI	1905	1924	2.30
Silent	1925	1944	28.60
Boomers	1945	1964	78.00
Gen X	1965	1984	82.90
Gen Y	1985	2004	86.60
Gen Z	2005	2024	40.90

So, whether we like what Gen Y represents or not, they, like us Baby Boomers, will redefine everything about work, socializing, families and much more. Remember, GenY is far bigger than any other generation.

Recruiting–the new rules

You might say, "If they are the largest cohort, there should be plenty of recruits!" Hold onto your hashtags; this will not be easy. GenY doesn't want to work with you if you don't fit into their schedule–and their schedule is all over the place. They make up the biggest chunk of the gig economy, many of them have two, three, or more jobs and side hustles, and they're just not going to put up with any "aggravation."

If you are successful attracting millennials, the challenge for long-term care providers is to figure out what their "aggravation" constitutes, make sure that it is avoided, and maintain superlative surveillance of their internal states. That way, when any aggravation looms, it would get addressed quickly. This generation (especially the native-born segment) has been raised to be self-assured and sensitive. Sarcastically, some have labeled them "snowflakes" and "social justice warriors." My sense is that

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The Moving Forward Nursing Home Quality Coalition–Taking action now

by Alice Bonner, PhD, RN, FAAN

This April, the National Academies of Sciences, Engineering & Medicine (NASEM) released a comprehensive report on nursing home quality ("The National Imperative to Improve Nursing Home Quality"). The report laid out key opportunities and challenges in nursing home care and began to envision system-wide reform. The report may be found here.

If you've been in long-term care for a while, the report may remind you of the Institute of Medicine (IOM) report in 1986 and the Nursing Home Reform Act that followed. Like its predecessor, the 2022 NASEM report offers an enormous opportunity for transformative efforts to improve the quality of life and work in nursing homes. And we need a groundswell of advocacy, activity and collaboration to achieve it.

The Moving Forward Coalition has come together to take the necessary steps and build community to make meaningful change. Officially convened in September, the Coalition is made up of seven committees, each working on one content area from the NASEM report. Over the last few months, administrators and advocates, residents and staff, and policymakers and researchers have prioritized one to two recommendations from the NASEM report they believe they can act on together over the next two years and beyond.

Those priorities will be posted on the Coalition's website for public feedback and comment by December 2nd.

Current, active discussions on these draft priorities have revealed a few common themes.

First, person-centered care has to inform all aspects of financing, delivery and oversight. Our committees have discussed the need to improve how we collect residents' goals, preferences, and priorities and ensure that care aligns with those goals using technology and clinical insights. They've identified the need for better measures of resident experience and health equity that are accessible and understandable to residents and their care partners. They've talked about how our financing system should be population-specific and should incentivize construction or renovation to produce more home-like buildings.

Second, long-term care finance reform needs to be part of a plan to better compensate staff. From alternative payment models to larger-scale Medicaid reform to efforts to introduce a federal long-term care insurance benefit, financing will underscore nursing homes' ability to better recruit, train, and retain direct-care staff and improve job quality.

Third, committees discussed the need to develop more progressive and integrated approaches to data transparency, quality assurance, and quality measurement. Our committee on quality assurance is looking closely at how surveyors, QIO-QINs, and providers can work to align oversight and improvement processes and incentivize more robust and integrated implementation of QAPI. Our committee on health information technology envisions pathways to HIT adoption that incentivize interoperability between nursing homes and larger health systems. And our ownership and transparency committee is talking about how to streamline data collection processes in ways that also make data more accessible and understandable to consumers and policymakers alike.

Finally, effective change must come from the ground up. Moving Forward's draft priorities reflect the sort of multi-stakeholder engagement and commitment to collaboration that resonates with many of us. We know that several nursing homes have already implemented innovative approaches to resident care delivery and quality of life, and to support for all staff members in their community. We want to continue highlighting those best practices, and to scale and spread them to additional nursing homes over time. If that resonates with you, we need your voice to accomplish our goals.

We're looking for partners to test and promote these initiatives in your networks, organizations, and health systems. Committees are committed to generating exciting new approaches to care delivery and oversight that can be tested in states and individual homes on the road to national implementation.

So, we need your help. We're looking for feedback on our one-pager priority overviews that will help us understand the approaches, policies and models you and your colleagues will commit to, consider testing in your communities, and advocate for. Please check back on our website to review those documents once they are posted in early December.

Could you test a new measure of resident experience in your home? Could your state host a demonstration of a new staff-empowering, resident-first payment model? Could you provide insights on how to get to full adoption of HIT? Could you call your local, state, or congressional legislators to inform them about this work?

It's time for the next big evolution in long-term care. We know what we need to do. It's going to take all of us to do it!

To participate in the Moving Forward Coalition, please click here to sign up on our website.

For more information, please reach out to Alice Bonner at abonner@movingforwardcoalition.org or Isaac Longobardi at ilongobardi@movingforwardcoalition.org.

Alice Bonner, PhD, RN, FAAN, has been a nurse practitioner for over 30 years. She is currently Senior Advisor for Aging at the Institute for Healthcare Improvement (IHI) and Chair of the Moving Forward Nursing Home Quality Coalition

PIONEERS & ROGUES: A family matter

We regularly feature a New England individual whose accomplishments–good or bad–helped to shape our profession. In this issue, we instead highlight a number of families that are or have owned and operated facilities.

by Bruce Glass, MBA, FACHCA

Our profession has a long and checkered history.

As Medicare and Medicaid opened investment opportunities in the early sixties, the lack of consistent regulations led to all too many national scandals.

But, here in New England–and across the country–many nursing home organizations predated these changes. Some can be traced to the passage of Social Security in 1935, when a nurse, or perhaps a widow with empty space, provided limited care in exchange for that monthly payment.

With the passage of time, some of these added wings to accommodate more "roomers." To this day, some of these buildings continue to exist. Others, of course, were replaced by the sterile design of mini-hospitals which are still all too common today.

In the 60s, with additional reimbursement available, many of these pioneering women involved other family members and continued to expand.

By 1980, most homes in Rhode Island, Massachusetts, and New Hampshire and many in Connecticut, Maine, and Vermont were family-owned.

Some of these family organizations provided outstanding care, such as the

Salmons in Massachusetts and the McKerleys in New Hampshire. Others skated along the edge, but, most were a cut above the corporate chains.

An example of the good and the bad was described in an earlier issue. Sisters Rita Welch and Edna Logan each developed and operated very good nursing homes on the South Shore of Massachusetts. Eventually they passed them on to the next generation. In the case of Welch, the growth continued as did the quality of service. Unfortunately, the Logans went in a different direction, running afoul of regulators and finances. Today, the third generation of Welches and Salmons continue the tradition of the founders, while the Logans are long gone and unlamented.

By the mid-eighties, corporate giants Beverly Enterprises and Hillhaven Corporation began aggressive expansion, swallowing some of the family operations. Many remained, but recent hard times have resulted in the loss of a number of family names.

It is most dramatic in Rhode Island. At one time the state strongly discouraged out-of-state operators. Now family names such as Ryan, Miga, and Kenoian are gone, as a new wave of corporations from New York and New Jersey have engulfed the Ocean State.

Similarly, the great majority of assisted living facilities throughout New England are owned by national corporations such as Atria and Brookdale.

The pioneers are gone, and at least some of the newbies are more rogue than not.

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.

SEEKING YOUR CONTENT

Please share your wisdom and expertise in *New England Administrator*.

The journal is sent quarterly to 1100 senior care professionals in the six-state New England region and is published by District One of the ACHCA.

Send queries to bruceglass@rocketmail.com

A case for the elimination of Medicaid trusts

by Norman J. Sczepanski, Jr., Senior Consultant, Strategic Care Solutions, LLP

Back in 1965 when it was founded, Medicaid was designed as a much-needed support program for the truly poor of America. It was projected to have an annual cost of $1.3B and increase at a relatively slow, modest rate. The initial projections were well off the mark, as costs increased by 50% per year on average, and the number of covered lives dramatically exceeded expectations.

The current annual tab for Medicaid spending is now over $672B with no growth slowdown in sight. What has happened since, is that the program has been effectively raided by lawyers and politicians to cover almost all Americans, even those possessing net worths in the millions of dollars. This raid has effectively shut down the private insurance market for long-term care, severely impacted both federal and state budgets and strangled the supply of funds available to support the long-term care industry, leaving it decimated and dying.

Where does the problem lie? Is it only with the very rich? The answer is no, the problem also includes the middle class who often have assets or net worth that could substantially cover the inevitable costs of end-of-life care. Why should we not all be responsible for the care that we know, with little uncertainty, will someday come? Medicaid, after all, was never intended to be an entitlement program for everyone, but rather a means-tested safety net to ensure health care for our truly needy fellow citizens.

The solution will need to come from both federal and state legislators with support of national organizations like AARP which must together recognize and speak to the undeniable facts that we are headed towards a national calamity without the enactment of substantive change. National health expenditures have already reached 19.7% of GDP. Looking at our position among other developed countries of the world we spend a significantly larger portion of GDP. Most recent world data from 2019 shows we are far above the rest. France, Germany, and Switzerland are between 11% and 12%. Canada, Australia, and the UK are between 10% and 11%. Along with elimination of self-induced poverty by trust we must also provide incentives for the purchase of long-term care insurance.

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TRUST

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Volunteerism and aging

by Sheldon Ornstein Ed.D, RN, LNHA

Volunteer services provide an attractive role for many aged individuals. Interestingly, women have traditionally volunteered, but the greatest increase in volunteering has been among elderly men. The number of older women who volunteer has remained relatively constant.

Statistically, 35% of the 65 and older population are engaged in some type of volunteer work. Most of the work is with religious organizations. Those who are involved as volunteers feel they are contributing to their community and are filling gaps in services that otherwise might be unmet. Their self-esteem and usefulness appears to prevail. Here is a list of several programs that include senior volunteer opportunities:

- National Network on Aging
- Nursing Home Ombudsman Program
- Foster Grandparent Program
- Retired Senior Volunteer Program
- Senior Companion Program
- Senior Corps of Retired Executives (SCORE)
- National Volunteer School Programs such as teacher aides.

Many of these programs consist of payment to volunteers or other inducements to supplement a low income. During these fiscally troubled times, it may be possible to attract more volunteers into these programs.

One particular reason for joining a volunteer group is the social component of contact with other volunteers of a similar generation. What about volunteering in a nursing home? This can be a meaningful and rewarding experience for senior citizens.

During my time working in long term care, I had a chance to peruse the facilities' monthly resident newsletters, and on occasion, participated in several of the various activities offered and listed below:

- songfests and singalongs with outside performers
- current news discussions with local newscasters
- friendly visits to those who were bedridden
- welcoming committee as representative to the newly admitted resident.

There are also counseling and training programs in which volunteers learn interviewing skills and develop their ability to deal with residents who are lonely and/or depressed. These particular roles have potential for elevating the resident's esteem and hold great potential for meeting the needs of many elderly. The older generation often can be skeptical of professional counseling but tend to readily accept help from their peers. Peer counseling programs have been appearing across the country. These programs train elders to help others deal with the major transitions of life such as relocation, loss of a spouse, retirement, or with the unanticipated crises that may come with growing old.

There are also programs for volunteers of interfaith orientation, and there are communities nationwide that have organized interfaith volunteer programs to provide in-home services for frail elders. These efforts have been organized and supported by the Robert Wood Johnson Foundation. The Interfaith Volunteer Caregivers program demonstrates the commitment of religious congregations that service the needs of those in the community. Initially, these programs were funded through religious denominations in 25 communities. Within three years, 900 participating congregations had recruited 11,000 volunteers and provided in-home services to over 26,000 individuals.

It appears that the volunteer role can be challenging in a positive way, and especially meaningful in later years to compensate for the potential loss of adult roles. Group involvement, along with volunteer work, has been seen as a major means of increasing life satisfaction.

A resident I once cared for expressed it as his "freeing" or role change, when he began doing some volunteer work in his choice of venue. "This is another stage of my life and a most exciting one. I have the time and freedom to develop new interests that I had always wanted to pursue but never could fit in when my life was so full of other things that didn't mean very much at the time."

Final Thought: For those who are seeking new ways, brighter days, and productive years ahead, volunteerism is a good option.

Quotable Quote

"Don't get all weird about getting older. Our age is merely the number of years the world has been enjoying us."
- 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.

The ghost of Christmas (and nursing homes) future

by Rick Gamache, FACHCA

I held my breath as the clock struck midnight. A bright light appeared beside me with a face that moved like flame.

"I am the ghost of nursing homes past. Take my hand and I will show you things as they were when you were a young administrator, full of hope and confidence."

With that I was swept through the winter air, above church spires, shopping malls, and bell-ringing Santas. "Rudolph the Red-Nosed Reindeer" blared from a loudspeaker.

"I know this place," I told the apparition as we hovered over a small nursing home. "I worked here in the 1980s."

The ghost said nothing as we entered the lobby.

"There's the director of nursing," I said. "We called her 'Nurse Ratched' behind her back."

"She had nicknames for you as well," said the spectral being.

I looked around. Nearly every resident was wearing a restraint. Most were strapped to wheelchairs, and their catheter bags touched the floor. I looked in one room where all three residents were tied into their beds. One stared directly at me through the siderail. She spoke to me, and I shivered.

"Are you my son?" she asked. "Are you a doctor? Help me, please!"

I turned to the ghost. "I didn't think people could see us."

"This resident is moving between worlds right now," said the spirit. "She is dying, all alone, like so many others."

"Can I help her?" I asked.

"What could you do?" the spirit asked me. "All these residents have lost their will to live."

"We restrained them because we thought it would keep them safe," I said. "We didn't know any better."

Just then a young man in a Brooks Brothers suit walked by. "Is that me?" I asked the ghost. "I look so stressed."

"Yes," said the spirit. "You are trying to make ends meet in a facility with a high Medicaid census."

"Some things haven't changed," I said.

The specter touched my hand and suddenly we were lifted away back to the familiarity of my office. I saw my reflection in the computer monitor. My hair was once again thin and gray. The photos of my grown children smiled back at me. I sat back in my chair and exhaled.

"Is that it?" I asked out loud. Then I heard a laugh. I spun around to see a large man with a wreath on his head like a crown.

"I am the ghost of nursing homes present," he bellowed. "Take hold of my robe and I will show you how things are now."

I could hear the song, "Simply Having a Wonderful Christmas Time," playing on someone's car radio.

"I already know how things are now," I said. "We're still under-reimbursed and over-regulated. There are no more restraints, but people still suffer and die from loneliness. By the way, I can't stand that song. I mean, I don't mind it the first few times, but by Thanksgiving I've heard it at least 300 times."

The specter laughed. "Forty years ago, you could never have imagined the challenges you face now. There's a deadly pandemic to deal with, a long-term care system that is

dysfunctional, and an unprecedented nationwide staff shortage. No one wants to work in this field. You were once young and optimistic, now you're neither, but you're still

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Trends in New England senior care

by Seth Wilson, CPA

New England skilled nursing facilities are showing some optimistic indicators, while other factors raise concern the industry is still far from recovering from the pandemic. In terms of profitability, the only state reporting a positive median operating margin (excluding public health emergency funds) was Connecticut. Many facilities continue to struggle with achieving target profitability due to challenges with occupancy, reimbursement, and labor.

This data and analysis come from CLA's 37th edition of its "Skilled Nursing Facility Cost Comparison and Industry Trends Report" with a macro perspective on national trends. Acknowledging regions, states, and counties have their own trends, a supplemental online dashboard was also released to present financial and operational key performance indicators for individual states.

For fiscal year 2021, the median occupancy for New England states ranged from 75% to 80%. Looking to more current data, at the end of September 2022, median occupancy rose to 80% to 85%. Recovery has been slow for some, better for others, but it's trending in the right direction. New Hampshire, however, barely achieved 80% occupancy by the end of June and fell back to 79% by September. In 2019, pre-COVID, New Hampshire's median occupancy was about 90%.

Margin is highly sensitive to payer mix and reimbursement. Five of the New England states had a median Medicaid mix greater than 60%. Vermont is unique, so it's difficult to gain insight on its mix from the Medicare cost report.

Medicaid reimbursement for long-term care requires operators to be very thoughtful in their strategy for balancing operations, patient outcomes, and financial performance. In some ways, reimbursement limits how much control a facility has over staffing hours and compensation.

Looking to staffing, five of the New England states had a median of approximately four paid hours per patient day. Maine was the exception with a median approximating five. These are reasonably healthy levels of staffing considering what some states have implemented for staffing mandates, cut points used by the Centers for Medicare & Medicaid Services (CMS) for the staffing component of the star rating, and benchmark to states in other parts of the country.

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Is immigration a solution to staffing woes?

by Ruth Katz

Our nation's economy needs robust immigration reform. This is neither a political nor a philosophical statement. It's the math. There are 6.1 million individuals seeking work in the United States today. We have over 11 million jobs.

To fill vacancies and account for turnover as well as keep up with the graying of the country's population, the aging sector will have to fill 7.8 million jobs by 2026. (PHI National, 2019) Most LeadingAge members report that as many as 20 percent of their positions are open, including certified nurse aides and personal care aides, dietary staff, housekeeping and maintenance, nurses, and social workers. For many of these jobs, there are no applicants.

The situation goes beyond aging services and covers all jobs; and the gap is expected to continue to grow. Unemployment is at record lows and stands at 3.7%.

To add to the challenges we face, aging services providers compete with retail, restaurants, and others to fill open positions. While most of these other service lines do not require the technical and clinical preparation and skills needed to work in long-term care, the pay bands are similar. (And we need to work on ensuring that wages and benefits match that level of professionalism needed on the front lines of aging services. But that's a question for another day.)

Many point to the pandemic as the cause for the aging services workforce crisis, but it is a demographic crisis, exacerbated by the COVID-19 pandemic. It's not going to go away when the public health emergency ends. But demography doesn't have to be destiny.

Where will the applicants come from? There simply are not enough people in this country to fill the aging services positions as well as all the other open jobs that keep our economy strong. Increasingly, aging services leaders are concluding that we must expand and simplify immigration pathways for motivated, trained, and committed people who want to work in our field and want to come to the United States.

Immigrants make up a quarter of the nursing home workforce and closer to 30% of the long-term services and supports (LTSS) workforce beyond nursing homes. In most cases, these are people who moved to the U.S., obtained work permits, and were hired by LTSS providers.

Many LeadingAge members–nonprofit and similarly mission-focused providers – have hired staff, mostly nurses, from overseas and

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TALKING DIRTY
with Ralph Peterson

The Burden of Leadership

If I were to define leadership in one word, the word would be, "responsible." That is what leadership is. Leaders are responsible. And responsibility is the burden of leadership.

If I were to define leadership in one word, it would be, "responsible." That is what leadership is. Leaders are responsible. And responsibility is the burden of leadership.

As much as it doesn't seem fair at times, especially to those of us who oversee a large, diverse, and sometimes uncooperative team, our customers expect nothing less. Our customers look to us (the managers) to ensure the products and or services they receive, are the same products and services they expected and paid for.

Honestly, I say fine. If that is the trade-off for being in charge, then I accept it. I will take full responsibility for all the outcomes of my staff. That is my job.

However, there has been a shift in the definition of the "burden of leadership" lately–and it's bordering on the absurd.

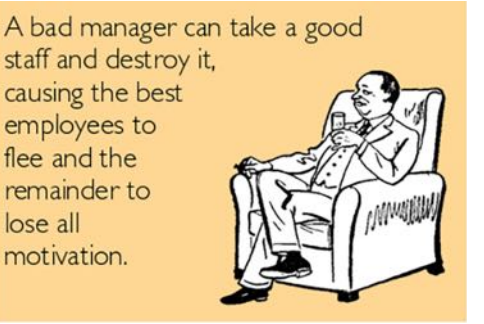
We've all seen the memes, dictums, and quotes: People don't leave bad jobs; they leave bad bosses. Bad bosses suck the life out of people.

My head spins every time I see people try to make a distinction between "leaders" vs. "managers" as if you can be one without the other. (PS: You can't.)

"A leader asks. A boss commands," according to one meme. "Leaders pull. Managers push," declares another.

Often, these quotes are accompanied by pictures of happy staff, willingly running up hill for the leader, while the manager needs a megaphone and a whip to get the same people to run down the hill. [Insert eye roll.]

Suddenly, the burden of leadership has shifted from the results of the team, to now include the behavior and actions of each individual team member–gasp–even when they are not working.



There are people out there who firmly believe that if I was any good at being a manager, ahem, I mean leader, none of my employees would have car issues or daycare issues. No one would oversleep or be in a bad mood. And of course, they would never sneak off, hide in an empty room to sleep, or scroll Tik Tok videos.

In fact, if I was a really good manager, all of my staff would get up two hours early every day, show up at least an hour earlier than they needed to, just to sit impatiently beside the time clock, itching to get to work.

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The Marketing Guru: Generational staffing crisis

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these observations highlight an important generational feature; Gen Y will not accept or tolerate what they see as aggression, irrational instruction, or "stupid" rules. These rules might include features of the work environment which Baby Boomers and Gen X have taken for granted: standard working hours, standardized recruitment and on-boarding procedures and–importantly–subordinating your personal agenda to your employer's.

Put analytically, the culture of long-term care operators must migrate quickly toward a highly personal, interactive, and supportive psychological and behavioral context. (Jack Welch is turning in his grave.)

Immigration

The history of immigration to the United States is highly varied. The average age of immigrants arriving in the United States is currently 31.6, which places them at the older edge of millennials. From 1985 to 2004 there were many immigrants, estimated to be 7.1 million, to the United States (including so-called "illegal" immigrants).

Prior to this, there was an immigration dearth. So, nursing homes and home care agencies, which relied upon immigrant women to provide personal care, were holding onto a dwindling cohort of female immigrant caregivers, and they have now been hung out to dry. Not only was there an immigration dearth prior to 1985, the COVID crisis drove many of these older immigrant women out of the direct care workforce, right into the local Amazon fulfillment center. Can we get them back? A few perhaps, but not many.

Solutions

There are no easy, silver-bullet solutions for the current staffing crisis within nursing centers. It is made worse by self-inflicted wounds of antiquated recruitment methods, inflexible staffing schedules, and Baby Boomer or Gen X leadership nostalgic for a time long since gone by.

First, schedules must be flexible. The limitations of the scheduling task aren't the schedule itself, but the cleverness of the people making the schedule. Human resources information systems (HRIS) can and should be an important investment for this very purpose. If feasible, an application ("app") can be created and distributed that allows individuals on their phones to adjust their start/end times and days. Long-term care truly is the land that modern technology left behind.

Second, long-term care providers must develop supervisory and leadership skills around behavioral and psychological support for staff. This generation, especially, stays or leaves based on their perceptions of their supervisors and their coworkers. The long-term care sector must quickly get much, much smarter about monitoring and supporting these critical psychological and behavioral dimensions.

Third, the sector must leapfrog into the digital age and recruit smarter. In the COVID-19 pandemic, temporary staffing agencies made a staggering amount of money, and they will begin to lose people. Long-term care providers must move immediately into digital recruitment, gamify the process, and treat recruitment like consumer-based marketing.

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You are the ghost of nursing homes future

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here. I give you credit for that."

"Thanks, I guess," I said. "These last few years have been the hardest, but in a strange way, they've also been the most rewarding. I've seen good people do extraordinary things every day. The courage and character of the staff has sustained me. Despite the difficulties, I have never been prouder of the work we do."

The spirit nodded. "I saw what caregivers did during the height of the pandemic. It was truly heroic. They were surrogate family members during dreadful times. And regarding the incessant and ubiquitous Christmas music, I am also sick of it already, especially "The Little Drummer Boy" by Bing Crosby and David Bowie. Whoever thought getting those two together to sing a duet was a good idea?"

"Probably the same people who designed nursing homes," I said. "Do you realize that the people who designed most current nursing homes were born before the Great Depression? Creating living environments that didn't accelerate the spread of deadly infections was not even on their radar. In fact, the word "radar" wasn't even on the radar."

The spirit chuckled, but his humor was waning. "It's a wonder you haven't all burned out," he said. "Very few people know how hard people work in long-term care. They have no idea how many mountains you climb every day. I don't know how you do it."

"You and me both, brother," I said, realizing I just referred to a ghost as "brother." "It seems so bleak sometimes. I wonder what the ghost of nursing homes future will show me?"

The spirit looked at me. "That's up to you," he said.

"Me? What do you mean?"

"The long-term care system in America is broken. It has been for a long time. The people who work in this field are the only reason anything good ever comes out of it. Out of sheer effort and will, and especially heart, you somehow spin gold out of straw for the elders entrusted to your care. But we need long-term care leaders to light the way, to create a better way forward.

"The care of older adults is a human rights issue, just as important as every other cause, and it's worth fighting for, but you and your peers must be spokespersons. Your influence can be as local as your own community, or as great as our country, but you cannot tolerate injustice. The future of nursing homes is up to you. Your staff wants you to lead them. The world needs your voice to help it heal."

I closed my eyes and shook my head. When I opened them, the ghost was gone.

I was alone in my office. I waited for the ghost of nursing homes future, but no one came. I saw a shadow in my computer screen, but with the help of glasses I realized it was just my reflection. I studied my face for a long time until it came to me. The image I was looking at was the ghost of nursing homes future. It was me.

What comes next for our noble profession and our sacred work depends on what I do, along with my peers and other stakeholders, to shape it. For our elders and for our staff, there's a lot at stake. Outside my office window, snow was falling on the brand-new day, and there was much work to be done.

Richard Gamache, MS, FACHCA, is CEO of Aldersbridge Communities in RI, and teaches Long Term Care Administration at RI College. He is also an item writer for the NAB exam and the assistant editor of New England Administrator.

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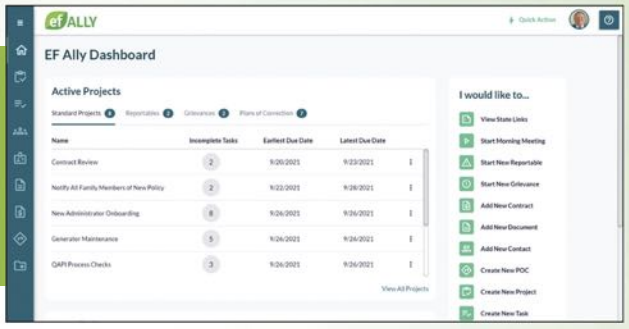

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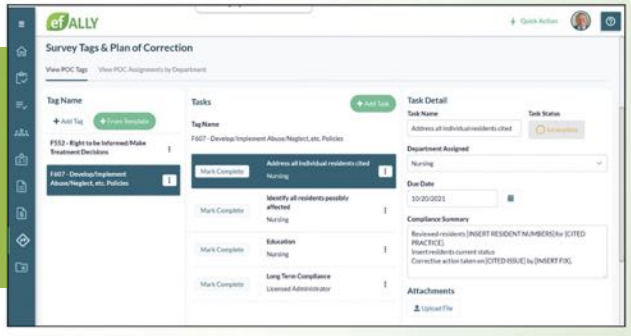

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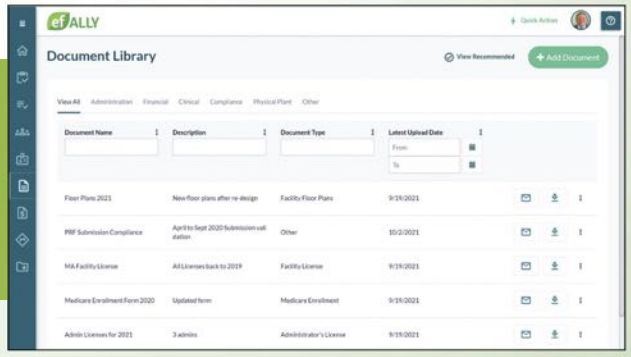

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Mixed KPI progress

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The staffing-related trend to watch is sustaining these levels as recruiting and retention becomes more difficult. Contract labor utilization has trended in a concerning direction for quite some time. The 2021 Medicare cost report shows more than 70% of facilities in every New England state uses some contract labor. New Hampshire is at 90% and Vermont is over 95%.

Beyond facilities using contract labor, it's important to understand how much they're using. For 2021, median utilization among facilities was over 10% for New Hampshire, Vermont, and Maine. Connecticut was the lowest at 3.5%.

Looking to more current data from CMS's Payroll Based Journal, median utilization of nurse aide contract labor for Maine and Vermont exceeded 20% by the first quarter of 2022. This is not surprising given the rural nature of those states. Still, all six states' use increased from the fourth quarter 2021 to the first quarter of 2022, with Connecticut increasing from 4.5% to 6.0%, breaking the 5% threshold. Massachusetts rose from 7.3% to 9.0%, approaching double digits.

There are various reasons this trend is so concerning. For facilities still looking to recover occupancy, there is a balancing act of admitting patients and residents and having the direct care staff to care for them.

Recall the median occupancy for New Hampshire being at or below 80% and 90% of those facilities utilizing contract labor. It puts stress on financial performance given the 40%+ markup paid for nursing agency versus employees.

Given the high percentage of patients and residents participating in Medicare and Medicaid, advocating for adequate reimbursement to invest in direct care workers is critical. In the meantime, understanding the numbers and making timely, strategic decisions is important.

Download a copy of the 37th annual SNF Cost Comparison and Industry Trends report and gain access to the state specific data.

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Immigration solution

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then spent years obtaining documentation and visas to help them move here and start working. A few larger LTSS providers have established their own agencies.

Congress found the courage and will to enact comprehensive immigration reform in 1965, aimed at reuniting families and attracting skilled labor, creating sweeping and lasting changes in the demographic makeup of the nation. Almost 30 years later, in large part to address illegal immigration, Congress stepped in to address border security.

Immigration reform is a "hot button" political issue, but another 30 years have passed and we've come to a critical juncture. LeadingAge's advocacy and policy work on immigration, as spelled out in IMAGINE: International Migration of Aging and Geriatric Workers in Response to the Needs of Elders and in our 2022 Policy Platform, aims for these important changes:

- Enact an aging services specific temporary guest worker program for certified nurse aides and home care workers/personal care workers.
- Expand the EB-3 visa program to allow more foreign-born nurses to enter the U.S. to work in aging services and to allow certified nurse aides to use the program as well.
- Modify the R-1 visa program to provide religious visas to temporary workers in faith-based organizations.
- Enact a new authority under the J-1 visa program to include aging services workers, along the same line as current authority related to childcare workers.

- Increase the number of refugees permitted to enter the U.S. and take steps to employ those refugees in the LTSS sector.

As the 117th Congress draws to a close at the end of 2022, there are a few bills we've been watching and will continue advocating for. Realistically, given the limited time left in this Congress, work on these measures is about laying groundwork for the next Congress, which will begin in January 2023. The current bills include:

- The Healthcare Workforce Resilience Act, a bipartisan, bicameral proposal would enhance the nation's nurse and physician workforce by recapturing 40,000 unused visas.
- The U.S. Citizenship Act, the Administration's bill–also bicameral but not bipartisan–would provide an earned pathway to citizenship.
- The Citizenship for Essential Workers Act–bicameral but not bipartisan–would allow undocumented persons working during the pandemic as essential workers to be eligible for a path to citizenship.

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The NEW ENGLAND ALLIANCE

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Immigration

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Like many immigration measures historically, these bills are limited in their reach. If Congress were to enact any of them, it would make a difference for aging services providers, but none of these measures alone represent the kind of large-scale immigration reform that is needed.

As we begin our work within a sharply divided political landscape, it will be important to keep in mind that the issue of illegal border crossing is not the same as promoting policies that allow qualified, motivated individuals to enter the country legally, using established– and new and expanded– authorities.

We commend the courage of some members of the 117th Congress for their efforts to try to address the barriers that create years, even decades long logjams for people wanting to immigrate to the U.S. Advocacy for these and other measures, as well as comprehensive reform, will continue. Whether to enact policies that allow more people to come here won't be a choice in the near future, it will be a necessity.

Ruth Katz is Senior Vice President for Policy for LeadingAge.

Talking dirty

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Then, once they clock in, they would run (not walk) to their units and quickly begin working, with huge smiles on their faces, while whistling Dixie. Their only complaint would come at the end of the day, when would have to go home.

What a crock of…you know what!

This is simply an attempt to shift personal responsibility away from the individual (employee) and blame everything on the manager.

"Well, if they treated us better…" they say.

Here's the real problem: A lot of who people believe it. Not me. Not for one second. If you haven't heard it lately, let me be the one to tell you: We wouldn't be anywhere without you, the manager. And thank God for you.

There isn't a single industry, including communications, automotive, farming, government, education, or healthcare, that could operate effectively without management. Without good, hardworking, and capable employees who said yes, when asked: "Will you take responsibility?"

If you are in any type of a leadership role, I personally want to thank you. The lights are on because of you. The doors are open because of you. Residents are being fed, and toileted, and showered, rehab patients are walking, comfort is being given, and lives are being extended, all because of you, the manager.

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

Ralph Peterson works with senior care organizations that are committed to developing their leadership teams so that they can learn how to solve tomorrow's problems today. To learn more call or text Ralph directly: (914) 656-0190

Eliminate Medicaid trusts

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The latter can be supported by tax incentives for both individuals and corporate employers.

The benefit of this action would accrue not only to federal and state budgets, but also to the struggling long-term care industry in America. Nursing homes are closing at an alarming rate. This is happening just before the aging baby boomer generation is set to accelerate the need for such care as never before.

Medicaid, with its payment rates lower than cost will be replaced by private insurance. This is not a complete panacea, as large and mighty insurance companies will no doubt try to control pricing, but it will be a competitive market. Facilities will have the option to contract with insurers who match their needs, or perhaps if not, refuse to do business with them. It must be better than what we live with today as perhaps 70 percent of facilities are losing money, due mainly to the inadequate payment rates by the Medicaid program.

The C.A.R.E.S. Expert

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from October 1, 2023 to October 1, 2025, CMS created an "Optional State Assessments" or OSAs so that Medicaid payments will not be adversely impacted. States can continue to use RUG-III or RUG-IV up until October 1, 2025. At that time, these states will need to convert their respective Medicaid State Case Mix methodologies via the Minimum Data Set (MDS) to the PDPM model.

If you are a state that is not one of the current Medicaid Case Mix States (i.e., Massachusetts), HHI strongly recommends implementing a PDPM system RUGS-IV 66 model sans rehab levels. This will save time and improve efficiencies on October 1, 2025 when all Medicaid state providers will be forced to transition to PDPM versus RUG-III and RUG-IV Case Mix methodology.

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New England Administrator

Published online quarterly by District One of the American College of Healthcare Administrators.

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arthur@TheARTofCom.com • 978-927-5343