New England
ADMINISTRATOR

March
2023

"A man with a new idea is a crank until the idea succeeds."
-Mark Twain

District One
ACHCA
American College of
Health Care Administrators

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Convocation & Expo
April 24 to 27

ALSO IN THIS ISSUE:

Death with dignity • Pioneer Bill Bogdanovich • Biden's industry reforms

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

C.A.R.E.S.™
HHI C.A.R.E.S. About Care
Compliance | Analysis | Audit | Regulatory | Rehabilitation
Reimbursement | Education | Efficiency | Survey

Capability Statement

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

Compliance
Analysis
Audit
Regulatory
Rehabilitation
Reimbursement
Education
Efficiency
Survey

Compliance

Auditing and Monitoring
Compliance Officer Services
Compliance Plan Development
Compliance Program Hotline
Compliance Program Review
Education and Training
HIPAA
Policy and Procedure Development
QAPI Program Development and Oversight
Response, Reporting and Prevention Guidance
Risk Analysis
Risk Management Analysis

Analysis

CASPER Report Analysis
Clinically Anticipated Stay (CAS) Analysis
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.

NWBOC WOSB CERTIFIED

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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NAB National Association of Long Term Care Administrator Boards
ANA American Nurses Association
ANCC American Nurses Credentialing Center

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Capability Statement

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Billing and Coding On-Site Mentoring
Compliance Auditing and Monitoring
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
Program Development
Therapy Staffing

Reimbursement

Accountable Care Organization
Billing
Bundled Payment
Comprehensive Joint Replacement (CJR)
Consolidated Billing
Cost Reporting
Managed Care
Medicaid
Medicare Part A and Part B
Pre and Post Pay Claims Review and Preparation (PREP)
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Value-Based Purchasing

Education (live, remote, public and private)

Certification and Competency Programs
Seminars
Symposium

Efficiency

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Interim Harmony HHI Specialist
Mentoring/Coaching
Placement: Interim and Permanent
Retention Program Development
Staff Talent Enrichment

Survey

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Adverse Events Focused Survey
Expert Witness Services
Facility Assessment
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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Benefits for Medicare Part A SNF residents

Clarifying Medicare rules

by Kris Mastrangelo, OTR/L, MBA, LNHA

"Your assumptions are your windows on the world. Scrub them off occasionally, or the light won't come in." - Isaac Asimov

This narrative is to help clarify the rules of Medicare and the benefits for Medicare Part A residents in a skilled nursing facility.

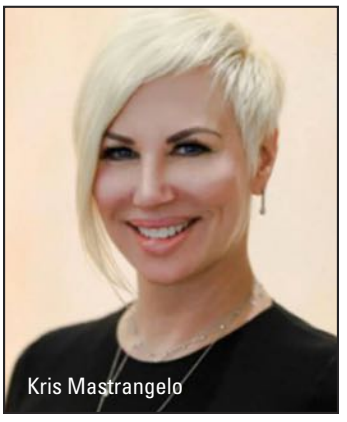
1. Observation and assessment: COVID-19-exposed

An HHI blog subscriber sent a question regarding skilling patients exposed to COVID-19.

"Kris Mastrangelo's recent blog states exposure to covid is a skilled need. I believe CMS and AAPACN have clarified this multiple times to be not accurate information. I am a moderator of a national Facebook group of tens of thousands of MDS nurses. Would love to discuss with Kris."

Observation and Assessment is a skilled qualifier when:

- Observation and assessment are needed to identify and evaluate the patient's need for treatment, or
- Observation and assessment are needed to identify and evaluate the patient's need for modification of treatment, or
- Observation and assessment are needed to identify and evaluate the patient's need for additional medical procedures, or
- There is a reasonable probability for complications or potential, or
- There is a reasonable probability for further acute episodes.



Kris Mastrangelo

A resident exposed to COVID-19 requires a nurse to observe and assess for signs and symptoms of COVID-19 in order to ensure medical safety and promote recovery. In April of 2020, CDC data depicted that 67% of deaths were individuals 65 years or older. Hence, there is no greater importance than assuring that this demographic is protected from the risk of mortality.

Examples of typical Observation and Assessment (meaning not in a COVID situation) from the Medicare Guidelines are depicted below::

Example 1: "A patient with congestive heart failure may require continuous close observation to detect signs of decompensation, abnormal fluid balance, or adverse effects resulting from prescribed medication(s) that serve as indicators for adjusting therapeutic measures." (Final Rule 7/31/99)

Example 2: "Similarly, surgical patients transferred from a hospital to an SNF while in the complicated, un-stabilized postoperative period, for example, after hip prosthesis or cataract surgery, may need continued close skilled monitoring for postoperative complications and adverse reaction." (Final Rule 7/31/99)

Example 3: "Patients who, in addition to their physical problems, exhibit acute psychological symptoms such as depression, anxiety, or agitation, may also require skilled observation and assessment by technical or professional personnel to ensure their safety or the safety of others, that is, to observe for indications of suicidal or hostile behavior. The need for services of this type must be documented by physicians' orders or nursing or therapy notes." (Final Rule 7/31/99)

As a reminder, if the skilled observation does not identify an issue, this does not negate the rationale or acceptability for skilled coverage.

As for COVID-19-exposed patients, if the skilled observation does not identify COVID-19, this does not negate the rationale or acceptability for skilled coverage. In fact, one could argue that skilled services may have prevented the spread. Seeing there is a reasonable probability of COVID-19 transmission, the observation and assessment criterion meets the requirement.

According to the CDC, "Isolation is for people who are ill, quarantine applies to people who have been in the presence of a disease but have not necessarily become sick themselves. Isolation separates sick people with a contagious disease from people who are not sick."

Isolation is for patients with symptoms and/or positive tests, whereas quarantine is

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What's REALLY possible for long-term care?

Have we reached A CRITICAL JUNCTURE?

by Irving L. Stackpole, RRT, MEd

Looking into the future is always risky–if there's any interest in being accurate.

Those of us working in long-term care are aware, many of us painfully and acutely aware, that we have the combined crisis of occupancy, revenue, unavailable labor, and declining public confidence. The path long-term care is on doesn't seem to be sustainable. My purpose here isn't to further agonize over the sources or root causes of this crisis but to try to understand what's possible[2] for the sector.[1]

The body of research, typically applied to urban planning, into comparative historical analysis and critical junctures is instructive in understanding what's possible. These models present us with ways of understanding how institutional change occurs and what's likely for the long-term care sector.

Irving L. Stackpole

Incremental or disruptive?

Based on critical juncture analysis, "there are two general modes of institutional change: incremental and more or less continuous adjustment and adaptation; and critical junctures of sudden and transformative change."[3] For example, the passage of the Social Security amendments of 1965[4] (SSA) represents a disruptive change based on political, social, and economic crises at the time. The amendments were intended to protect the aged, children, and other vulnerable persons from destitution and hardship; a clear and present memory among the legislators and the public at that time. And the institutions and systems that the SSA created have been extremely durable and long lasting, despite the fact that they are now, in many ways, no longer fit for their purpose.

The changes we've seen since 1965, which affect long-term care are incremental changes brought to us through the institutions created by or empowered through the SSA. Considering this type of incremental change, there's no doubt that LTC will continue to see more accretive regulatory pressure to mandate staffing, moderate prescriptions, master contagion, and mitigate loneliness through dictates about access to the consumer. My questions here are: Where will this lead the sector, and; are we nearing the point (or perhaps there) where more incremental change is refractory to meaningful results? An affirmative answer to the latter might lead to a critical juncture.

Are we at or near a critical juncture?

Critical junctures are types of social, political, and economic disruptions, which can occur in relatively brief periods, and where previously stable institutions are transformed and new approaches–new pathways–established. Critical juncture is the point at which the social contract can no longer be fulfilled, available alternatives are evaluated, and choices are made based on the unacceptability of the current situation.

We should try to determine whether the current crisis (a nexus of problems) is sufficiently painful and unacceptable to prompt substantial changes to:

- How CMS regulates (political);
- How capital is formed and invested in the sector (infrastructure);
- How intermediaries pay for services (economic);
- How the public sees long-term care (social);
- Substantially increase the technologies deployed (technology);
- The body of jurisprudence (legal), and/or;
- Make the sector environmentally more sustainable?

American society overall is racing away from the experience of the pandemic and its related issues is fast as possible. The deaths and failures of our long-term care institutions are already receding from the public consciousness. The publicly acknowledged inadequacy of the direct care workforce is morphing into discussions about labor actions such as strikes and walkouts, shifting the rhetoric away from the underlying inade-

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by Bob Lane, MA, CNHA, FACHCA, ACHCA
President & CEO

Greetings, ACHCA colleagues!

The new year always brings a sense of reset; a chance to reevaluate our priorities, to set a course for a better tomorrow. I know I always look forward to the first part of a year. Why? Many reasons, but high up there on my list is…Convocation!

With the advent of spring comes our annual Convocation and Expo, this year set for April 24 to 27 in Baltimore. This year's event, our 56th by the way, will be held at the Hilton Inner Harbor, which is a great venue for convocation, as well as its proximity to The Ballpark at Camden Yards, the home of the Baltimore Orioles. It just so happens the Os will be hosting a team from Boston (go Sox!) for a series at the same time as our event, so in addition to the many exciting activities occurring at Convocation, it's a natural for us to tie into the baseball theme.

Some changes you will note for this year's Convocation include:

1. In response to your feedback, we'll have a free evening on Tuesday, April 25, right after our Chair's Welcome Reception. Feel free to go to the ballgame, out to eat at the many choices in Baltimore, or shopping; the choice is yours.
2. We'll be presenting the Lean Six Sigma yellow belt track, which was postponed from our New Orleans event last year. Attendees who register for this program will be eligible for the yellow belt designation and will have a leg up on assuring successful quality improvement efforts in their communities.
3. Also new for this year is an Assisted Living track, with multiple sessions geared strictly for the AL administrator. ACHCA is about representing the interests of all post-acute leaders, so this is a step in the right direction.
4. A student track for those students attending who are working toward their degrees in health administration.
5. A session (and Idea Exchange table) to cover our revived certification credentials. Don't miss this opportunity to learn more about the new and improved program and the many benefits of pursuing/renewing your certification in nursing home or assisted living administration.
6. A plenary session on the Moving Forward Coalition, presented by Dr. Alice Bonner.
7. An Academy for Long-Term Care Leadership and Development fundraising reception, just prior to our awards banquet on Wednesday evening.
8. And last, but absolutely not least, our awards banquet, feting our many award winners, and the induction of our second class of the ACHCA Hall of Fame.
9. Finally, our annual Member Forum, which this year will feature several emerging professionals who will discuss their experiences as they began their careers.

All in all, this shapes up to be a very full event, one I hope you'll plan to attend. Early-bird registration ends March 17, and early-bird deadline for hotel reservations ends March 31, so don't miss out. I'll look forward to seeing you in Baltimore, where you can "do more, be more, and learn more" in Baltimore.

Death with dignity in New England

by K.R. Kaffenberger, PhD

Long term care facilities in the United States are believed to be the site of a significant number of suicides each year. The Kaiser Family Foundation estimated there were several hundred a year among residents. Very few of these deaths would have been legally sanctioned. In part that is because today only 9 states have laws that permit death with dignity. Many states are currently considering medically assisted dying legislation.

Currently California, Hawaii, Montana, Maine, New Jersey, New Mexico, Oregon, Vermont and Washington have death with dignity laws, as does the District of Columbia. Many other states are engaged in policy debates. Repeals have been unsuccessful. The thumbnail arguments are clear.

Laws against suicide are based on the sanctity of life and the preservation of social order. Human life must not be taken out of a person's transient dissatisfaction with life or due to abnormal mental status. Nor may people have the right to eliminate another's life because it suits their own purposes.

Death with dignity is invoked when death in the short term is a foregone conclusion, and the dying person is of sound mind. Being able to choose death preserves the autonomy of the dying person and may avoid physical and emotional agony in the last days of life.

It is a kind of argument between sanctity and humanity. It is a difficult argument because those arguing in favor of sanctity are also humane and those arguing for humanity also accept the sanctity of life.

Two of the northern New England states, Vermont and Maine, have death with dignity laws. The Vermont Patient Choice and Control at End of Life Act (Act 39) was signed into law by Governor Shumlin and has been in effect since 2013. In 2015 a sunset clause was removed. In 2022 Governor Scott signed S74 into law which eliminated the need for personal contact for medication requests. It also allowed distant examination, removed a 48-hour waiting period, and extended legal immunities to those acting in good faith. Current legislative proposals would remove a requirement for Vermont residency.

In 2019 Governor Mills signed the Maine Death with Dignity Act into law. Passage followed a five-year campaign over three legislative sessions. It often takes years to gather the necessary legislative and gubernatorial support to pass and sign bills into law.

Efforts are ongoing in other New England States. There is currently no medically assisted suicide legislation pending in New Hampshire. However, there were several legislative attempts in the 1990s, and bills were filed in 2010, 2011, 2014, and passed in 2015 but vetoed by Governor Hassan. Bills were also filed in 2016, 2018, 2019, and 2020.

Connecticut has had a similar history. There have been a long series of bills filed since 1995. A bill has been filed each year since 2017. None of these bills has made it beyond the Joint Committee on Public Health.

In Rhode Island the Lila Mansfield Sapinsley Compassionate Care Act has been introduced and referred to the House and Senate Judiciary Committee. A similar bill was filed in 2022.

In Massachusetts the first bill was filed in 2012 and each year from 2013 to 2017. That year the Massachusetts Medical Society, which had opposed physician participation in medically assisted dying, moved to a neutral position. The 2018 bill was referred for study.

In 2020 the national Death with Dignity website noted that the Massachusetts bill had "overwhelming public support." In 2021 the bills were reintroduced and sponsored by 20 senators and 47 representatives but did not advance beyond the joint public health committee. Despite increased support the legislation did not move beyond committee in 2022. Experts believe that the votes were there to pass the bills, however many thought Governor Baker would veto the bill.

In recent years some of the ideas and disagreement surrounding medically assisted dying has played out in the Boston Globe. In December of 2022 the Globe's editorial board endorsed the proposed changes and wrote, "To ease suffering for dying patients, Massachusetts should legalize medically assisted death… .What interest could the state possibly have in preventing a patient suffering from an incurable illness, and poised to live the last few months in extreme pain, from peacefully dying on their own terms?"

The endorsement noted several points. The candidate must be terminally ill, of sound mind, be carefully examined by clinicians to confirm their condition, and have opportunity to change his/her mind. Although more than 5,000 people have chosen such deaths in US jurisdictions where it is legal there is no documented case of abuse of any individual. A Death with Dignity law would give appropriate individuals the chance to choose not to die in extreme pain.

Jeff Jacoby, a Globe columnist, wrote an opinion piece titled "Assisted Suicides Slippery Slope – In Canada the 'right to die' now claims more than 10,000 lives each year." Jacoby said that Massachusetts voters voted down a referendum on assisted suicide in 2012 and that the legislature is trying to overturn the popular will. He also pointed out that state courts have upheld the existing ban. He questions why the authority to die by starvation or dehydration are not adequate for those who wish to hasten their own deaths.

Jacoby argues that over time the "right to die" laws will become less restrictive so that permitting doctors to prescribe death is a slippery slope. He points out that in Canada many of the guard rails have been removed. He says that "assisted death" is available to Canadians who are not terminally ill, and that mental illness will soon be a justification for requesting death. Jacoby also called up the specter of financial concerns contributing to requests for death.

Jacoby's column met with a flurry of letters. Many pointed out that some form of medically assisted dying has been in place in the United States for more than 25 years with no recorded cases of coercion or abuse; that the United States is

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PIONEERS & ROGUES: Bill Bogdanovich

We regularly feature a New England individual whose accomplishments–good or bad–helped to shape our profession. In this issue, we we are featuring a true pioneer from Massachusetts: Bill Bogdanovich, CNHA, CALA, CAS, FACHCA.

by Rick Gamache, FACHCA

Bill Bogdanovich started his career in nursing homes as a dishwasher and worked his way through training to become an administrator in 1987, which is the same year he joined ACHCA. Today, Bill is President and CEO of Broad Reach Healthcare, a continuum of services for older adults located in North Chatham on Cape Cod.

The flagship of Broad Reach Healthcare is Liberty Commons, an innovative skilled nursing community with a capacity to care for 132 older adults. Other features within the Broad Reach portfolio are a 40-apartment assisted living residence, an out-patient rehabilitation clinic, a comprehensive hospice program, and more.

As a longtime College member, Bill is well known within our profession and has a much-deserved reputation as a forward thinker and compassionate leader. In 2018, several local and regional media outlets featured the story of a bold recruitment and retention strategy Bill created to attract staff members in the notoriously difficult labor market of Cape Cod. Bill began purchasing residential properties located within geographic proximity to Liberty Commons and offered workforce-affordable housing at below-market rents to his employees.

The population on Cape Cod swells during the summer, as vacationers flock to beaches, and restaurants and retailers compete for seasonal hires. The cost of housing also grows exponentially at that time. After Labor Day, the population on the Cape decreases, but the workforce shrinks, too. By offering rents for his employees that are not driven by whatever the market will bear, Bill's organization has been able to avoid some of the ebb and flow of turnover that is affecting everyone.


Bill Bogdanovich

That's not to say that Broad Reach Healthcare is immune to the impact of the unprecedented labor shortage within long-term care across the U.S., but retention rates for staff at Liberty Commons have consistently averaged fifty percentage points better than national and state averages.

Providing more affordable housing for staff is only one component of Bill's vision to create a workforce-friendly culture. For example, Broad Reach has long offered its employees emergency loans when they encounter a financial hardship. The "Helping Hands" fund exists to assist a staff member with an unexpected expense or a larger-than-expected utility bill that can be paid back through payroll deductions, interest-free.

Currently, about 10% of the company's employees live in Broad Reach's workforce housing. They are not required to come up with an up-front first month/last month down payment or a security deposit. They are, however, required to remain employed by Broad Reach to continue receiving premium rent-structure and other benefits. Broad Reach even allows these employee-tenants to defer their rent when expenses like high winter utility bills spike.

The actions of their president and CEO clearly communicate to Broad Reach's staff that they work in an organization where they matter, and where leadership cares about them. In the current labor market, demonstrating care for employees is essential to survive. Bill Bogdanovich has been ahead of that curve for years.

After all this time in the profession, I asked Bill what keeps him going. He takes pride in seeing the accomplishments of people he has hired and mentored, he states. But I think it's more. In my short conversation with him I could sense that he loves staying one step ahead of the competition. He was comparing his competitor's PBJ data to his own when I called. Earlier, he was meeting with a group of new employees to welcome them to Broad Reach Healthcare and share the organization's unique culture.

Bill stays balanced, never allowing himself to get too high or too low, which has become more difficult than ever before. He says the nursing home environment, (the over-regulated, under-funded, short-staffed-while-dealing-with-a-pandemic side) is not forgiving. To succeed, he believes one must accept that it's an assignment of responsibility that just doesn't exist the same way in other business sectors or professions, and that you must create a sense of personal agency over it, controlling what you can, rolling with what you cannot. Even at its most challenging, Bill believes a leader in aging services can be successful, provided they are with the right organization.

In the middle of Cape Cod, Bill Bogdanovich has created such a place.

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.

SEEKING YOUR CONTENT

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

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Send queries to bruceglass@rocketmail.com

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Anxiety, worry and aging

by Sheldon Ornstein Ed.D, RN, LNHA

According to the researcher Hogstel, "Anxiety is a diffuse feeling of panic, dread and lack of control that can be insufferable in its acute stages." He further states, "Little is known about anxiety and its numerous manifestations even when it has not reached negative clinical proportions. It is a multi-response to helplessness, isolation, alienation and emotional insecurity. Evidence of anxiety in the elderly is often not as apparent as in younger clients. Anxiety is the motor that keeps people moving toward mastery of new and threatening situations."

The researchers Jarvik & Russell claim, "Anxiety runs with a soft, pleasurable purr that is not always perceptible. However, when it's an extreme or prolonged personal stress, it is likely to initiate episodes of anxiety that is experienced as a noticeable jittering hum in the gastric area."

"Elderly people who are experiencing stress, don't usually react in the same way as a young person." Jarvik & Russell further suggest, "Aged people do not fight or flee when endangered. Instead they develop a passive freeze reaction. Fighting or fleeing requires a heavy physical expenditure that is not appropriate or possible for many aged individuals. The term 'freezing' does not imply a means of giving up but rather is a form of energy conservation in response to chronic issues, a lack of privacy and pervasive apathy."

Unrelenting anxiety of a persistent and chronic nature may very well require a need for what is known as a crisis intervention. The following illustrates how this is employed and in the form of a case study that can demonstrate how the technique functions.

Case Study

Mrs. S was brought to the nursing home without her consent or any prior preparation. She sits mutely, staring out the window of her room. The nurse assigned to orient Mrs. S to the facility's surroundings, recognizes the importance of the situation but is uncertain of Mrs. S's perception of her admission. The nurse enters with the following conversation taking place. (Note: the nurse is Nurse D, and the newly arrived resident is Mrs. S.)

Nurse D: "Mrs. S, I am Nurse D. I noticed you were looking out the window as I came in the room. Is there anyone you were looking for?"

Mrs. S: Not moving and muttering, "I am lost…lost," she declares.

Nurse D: "You may feel lost, but I am here to assist you. Tell me what happened today."

Mrs. S: "I am lost…no one wants me!"

Nurse D: The nurse repeats, "Tell me what happened today"

Mrs. S: "They didn't tell me!"

Nurse D: "Who are they you are referring to?"

Mrs. S: "My daughter, she left me here!"

Nurse D: "Mrs. S, this must be a terrible time for you!"

Mrs. S: (beginning to cry) "You don't know–you're young."

Nurse D: "You are right, I am young, but I still want to help if I can."

Mrs. S: "No one can help" (she sobs inconsolably).

Nurse D: "Come with me to the kitchen, and we'll have a cup of fresh coffee and talk about it."

Mrs. S: "It won't help."

Nurse D: "You have a right to be angry and upset."

Mrs. S: "I am not angry…I am lost."

Nurse D: "Come!" Nurse D urges her. "I'll show you where we can get some freshly brewed coffee and I'll even stay with you for a while and talk."

Mrs. S and Nurse D walk to the kitchen, however reluctantly, hand-in-hand.

What has Nurse D been able to accomplish in this scenario?

- Conveyed a supportive relationship with a calm and reassuring approach
- Avoided suggesting to Mrs. S any misunderstanding about her "new home"
- Stimulated the resident's interest and an offer of a past comforting routine of a cup of hot coffee
- Voiced several opportunities to sort out any misperceptions related to Mrs. S's admission to the facility, her immediate surroundings, where dining service occurs, the many activities the home has to offer, and some of the friendly residents in her area she can chat with and get to know

The research further offers another aspect about the chronicity of worrying, i.e. "worrying can foment confusion with the elderly person." Mrs. S clearly shows confusion as she continues to worry over her predicament.

There are several other common perceptions concerning the concept of stress as it relates to worry and anxiety and that can adversely affect the decline in the aging process. They are: increased potential for falls, dwindling finances, decreased opportunities for social engagement, or a loved one's decline in health.

The researcher Borkovee refers to the concept of worry in the elderly as "a limited emotion." He further states, "The uncontrollability of negative thoughts and images is a central component of worry." Additionally, Borkovee says, "An older person who is in a crisis mode may be radically different from a younger person." The presence of a chronic psychological problem can, over time, worsen and decrease the elderly individual's ability to continue managing independently. Also the likelihood of living alone can further produce a situation that may require more than a single crisis intervention session.

Final Thoughts

Here are several recommendations when caring for an elderly loved one who is exhibiting

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The final salute

by William R. Losefsky, CHPA,CMI,CPM, CIRM

Imagine sitting down to breakfast and then noticing that one of your fellow residents is not sitting at the breakfast table at his usual customary spot. That is when fellow residents would first find out that one of their comrades had passed away. Earlier in the evening, the resident had expired and was shuttled out the freight loading dock into a waiting hearse. This was how the death process was dealt with before we instituted the "final salute" protocol.

The New Hampshire Veterans Home felt that the resident was welcomed through the front door as a new admission, and he should go out that same front door on his final departure. We then worked on coming up with a process that is now known as the "final salute."

We put together a process in which we place an American flag over the gurney of a deceased resident. We then escort the body and lead the deceased resident to our common area by the dining room. The residents are called to attention by the resident council president. We created a short final prayer that reads:

It greatly moved the staff as well as the residents and visitors. All we could think of is that we should have been doing this sooner.

"(Resident's name) is now leaving the veterans home on his/her heavenly departure. May (resident's name) now rest in peace. We thank you for your honorable service to your country in its time of need."

We then salute the deceased resident, and the resident counsel president chants "two." A uniformed security officer escorts the body down the elevator to the main entrance of the facility and out the front door– a show of dignity and respect. The American flag is then removed from the deceased resident prior to being loaded into the funeral director's vehicle, and the flag is then ceremoniously folded and prepared for further service.

We announce over the public address system that the resident has passed, and we ask for a moment of silence as we ring a brass bell three times in somber remembrance of the resident. This "final salute" protocol has been extremely well received by the residents as they now have proper closure in saying good-bye to their comrades in arms. Many of our residents are not physically capable of actually attending the service. This is a small example of how the safety and security department goes the extra mile in the service aspect in understanding our customers' needs. The final salute was recognized in the Quality of Life award in New Hampshire and was given a standing ovation.

The first time we did this, we were amazed at the military bearing that a 90-year-old wheelchair-bound war veteran was able to muster. Many stood up from their wheelchairs and others had to use two hands to snap a salute due to a stroke. It greatly moved the staff as well as the residents and visitors. All we could think of is that we should have been doing this sooner.

We slowly integrated having the escorting security officer wear white gloves. Many of our officers keep their shoes and boots at a high level of readiness as General George S. Patton was well know for saying, "You are always on parade."

Many of our residents pass away at a hospital. We designed a plan for that as well. If the resident passes away from the facility we continue to have the procession walk. Instead of escorting the deceased resident's gurney, the security officer carries a crisp, folded American flag. The security officer walks the length of the hall and stops at the exact location as if the body was at rest. The same exact ceremony is conducted with the security officer holding the flag in symbolic remembrance of the resident.

My hope is that other long-term care facilities can introduce an act of remembrance for their residents. The "final salute" process does not have to be as elaborate as ours and can build over time. I would suggest involving the residents and the resident council as much as possible. A long-term care facility is the last "home" that a person will have and their passing should be something more than a ride through a loading dock.

William R, Losefsky, CHPA,CMI,CPM, CIRM, is director of safety, security and emergency management at the New Hampshire State Veterans Home.

Death with dignity

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not Canada; and that recent polls indicate that 77% of Massachusetts residents approve an assisted death option.

J.M. Sorrell, executive director of Massachusetts Death with Dignity, feels that 2023 is likely to be the year that the law finally passes in Massachusetts. Governor Healy is expected to support such a law, and sponsors include half of state senators and about 35% of state representatives. There are expected to be many legislators who are not currently expressing support but will vote for the bills. The Globe estimate that 77% of residents favor the bills is important for elected officials.

If these bills become law, leaders in health care will need to take appropriate actions. For those in assisted living facilities and skilled nursing facilities there will need to be policies to deal with requests for medical assistance in dying. Individual physicians will be permitted to refuse to participate. But will facility medical directors be permitted to refuse for the facility? How may other facility leaders and workers opt out? The bills suggest that if a facility opts out it must refer the resident to another compliant site.

For facilities supporting residents who choose medically assisted dying, how will that support be provided? Some level of leadership understanding will be needed to write policies and procedures. In service training will be needed for health workers. It may be that states such as Oregon which have had Death with Dignity laws in place for decades will provide valuable examples as New England states grapple with the future of such laws. The questions are numerous and will need answers.

K.R. Kaffenberger is a former nursing home owner and Adjunct Professor of Gerotology at UMass Boston.

Biden's nursing home industry reforms

by Alexandra Maulden and Lawrence W. Vernaglia

In early 2022, the White House unveiled a range of policy proposals that could have an immense impact on the nursing home industry. In his State of the Union address, President Biden announced a crackdown on companies allegedly overcharging American businesses and consumers and highlighted the nursing home industry as one sector he was intent on reforming. He vowed that "Medicare [would] set higher standards for nursing homes and make sure your loved ones get the care they deserve and expect."

As part of these proposed reforms, the Biden administration announced three general goals for the Department of Health and Human Service to improve the quality and safety of nursing homes.

1. Ensure taxpayer dollars support nursing homes that provide safe, adequate, and dignified care
2. Enhance accountability and oversight
3. Increase transparency

Each goal had various proposed initiatives to help accomplish the overall objective. Some of these initiatives, particularly within the goal of enhancing accountability and oversight, are not possible without the help of Congress, but other initiatives will be directly implemented through appropriate regulatory agency actions.

Nurse staffing ratios

Within the first goal of providing safe, adequate, and dignified care, a lack of available, qualified workforce is one of the biggest obstacles to the industry. To address this, the Biden administration vowed to set a minimum nursing home staffing requirement. It instructed the Centers for Medicare & Medicaid Services (CMS) to conduct a new study to determine the necessary level and type of staffing needed to provide safe and effective care.

The administration stated that new proposed rules implementing these findings would be announced within one year. If this timeline holds, we would expect new proposed rules in early March. At the time this was written, there have not been any new proposed rules related to nursing home staffing requirements.

Understandably, this initiative has received extreme pushback from the nursing home industry. Nursing home administrators and staff have

two major concerns: 1) significant workforce shortages already exist within this industry, and increasing staffing requirements does not address the issue of not being able to find qualified staff to fill the new positions, and 2) CMS has not committed to providing adequate (if any) funding to help implement the mandate. A mandated nurse staffing ratio without support for recruiting and paying for them is nothing

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TALKING DIRTY
with Ralph Peterson

You're not short-staffed, you're short-sighted

I NEVER KNEW WHICH CALLS WERE WORSE, the calls I would get in the morning from nurses complaining they didn't have everything they needed, or the calls I would get in the afternoon, complaining that we didn't get everything done. I hated them both.

Of course, there were two other calls I hated even more. The first was a call out. Although admittedly I do reminisce sometimes about the old days when, to call out sick, you had to actually talk to someone, and you had to sound sick. That is when calling out was fun. Back when you had to work hard to make your voice sound all horse and scratchy–so that you sounded like you were knocking on death's door, even though you weren't. But I digress.

As much as I hated it when employees called out, the worst type of call was when they wouldn't call at all. It's a weird dichotomy to find yourself in; I hated it when they called, and I hated it when they didn't.

I remember sitting in this tiny office in the basement of a nursing home. Every time the phone rang, I thought about quitting. I would let the phone ring and ring, before finally, taking a deep breath and letting it out slowly.

"This is Ralph," I would say, hoping it wasn't a call out. It usually was.

After a while, callouts became so common and being short-staffed so normal that we all started to use it as an excuse, even when we weren't short-staffed. Anytime we didn't get things done and someone complained, we all said the same thing, "We are short-staffed, you know."

Suddenly, not getting our jobs done was not our fault. It was out of our control, and we used it to our advantage.

It was a family member that finally set me straight. Not one of my family members, to be clear, a resident's family member. She was in the administrator's office, asking to talk with all the managers, from every department. We all came in, rolling our eyes at each other, anticipating the hostility, and armed with our favorite excuse. But she wasn't angry. She sat in one of the oversized chairs and told us about her morning.

She arrived at 6:45am, concerned that her mom wasn't getting the time and attention she deserved. She was there during AM care and saw all the blinking lights begging for attention. She heard all the calls for help, and she watched all the nurses and aides shuffle around with their faces glued to their phones, with no sense of urgency.

Continued on last page

The C.A.R.E.S. Expert: Clarifying rules regarding benefits for Medicare Part A SNF residents

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for patients exposed but exhibits no symptoms. HHI proclaims that COVID-19-exposed residents require the daily skills of a nurse to observe and assess for signs and symptoms of COVID-19.

Daily Skilled Nursing COVID-19 Quarantined and Isolated (An excerpt from the HHI Core Components.)

Secondary to the patient's positive COVID-19 diagnosis, or the patient's potential COVID-19 diagnosis, the skills of a nurse are required to assess the patient's changing medical condition, and the reasonable probability for complications. A COVID-19-positive patient inherently requires skilled nursing to identify and evaluate the need for modification of treatment and to assess for additional medical procedures until the patient's medical condition is stabilized. A COVID-19-exposed patient inherently requires skilled nursing to identify and evaluate the need for modification of treatment and to assess for additional medical procedures until the patient's medical condition is stabilized.

According to the CDC, symptoms can range from mild to severe and may appear up to two weeks after exposure to the virus. The rationale for skilled nursing observation and assessment of COVID-19-positive and COVID-19-exposed is as follows:

- Skilled nursing for observation and assessment of signs and symptoms of exacerbation of dehydration, septicemia, pneumonia, nutritional risk, weight loss, blood sugar control, impaired cognition, mood and behavior conditions, cardio complications, and pulmonary complications.
- Skilled nursing for observation and assessment of signs and symptoms of fever, rash, cognitive changes, cough, shortness of breath, difficulty breathing, chills, shaking with chills, muscle pain, headache, and sore throat.
- Skilled nursing for observation and assessment of proper infection control procedures and compliance as well as isolation and quarantine procedures.
- Skilled nursing for observation and assessment of pulse oximetry, loss of taste or smell, treatments and conditions that arose secondary to isolation and quarantine, .
- Skilled nursing for observation and assessment of signs and symptoms related to exacerbation of COVID and exacerbation of current or prior diagnoses.
- Overall management of care plan to ensure medical safety and promote recovery.
- Skilled teaching and training activities for pulmonary hygiene, avoidance of infection and irritants, importance of rest, importance of prompt reporting of signs of recurrence of pneumonia, and medication regimen.

2. Essentially stabilized

The caller also included the below excerpt which further supports HHI's position that the daily skills of a nurse are required to observe and assess the patient when the likelihood of change exists.

30.2.3.2 Observation and Assessment of Patient's Condition: "Observation and assessment are skilled services when the likelihood of change in a patient's condition requires skilled nursing or skilled rehabilitation personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures, until the patient's condition is essentially stabilized."

The caller bolded "essentially stabilized," of which HHI agrees and feels compelled to expound on these quoted words. The daily observation and assessment skills of a nurse are skilled until the resident's treatment regimen is essentially stabilized, and the resident does not have the need for additional procedures, modifications, or treatment changes.

3. Treatment or conditions

Per the Medicare SNF Guidelines, the skilled rationale includes: "Treated for a condition which was treated during a qualified stay…or… which arose while in a SNF for a treatment of condition for which the beneficiary previously was treated in a hospital…treatments or conditions that arose secondary to isolation or quarantine."

For example:

- Factured hip develops pneumonia secondary to immobility. Skilled nursing for the pneumonia.
- Fractured hip develops swallowing issues secondary to immobility. Skilled Speech Therapy services rendered for swallowing.
- An isolated patient's anxiety is exacerbated due to isolation. The skilled coverage criterion transcends to overall management of care plan to ensure medical safety and promote recovery in relation to the resident's anxiety.

Perhaps, these skilled opportunities are more obvious to me as a therapist because this has been the foundation for skilled therapy since the beginning of Medicare Coverage criterion.

4. COVID-19-positive skilled or not skilled

The caller stated that she had, in writing, that CMS disallows skilling the COVID-19 positive patient. I asked for this proof, and she sent below: (Please note, caller emailed CMS while we were on the phone.)

On Tue, Jan 24, 2023, at 6:03 PM: Waiver for a positive test. Please see CMS COVID-19 FAQs, section X:6.

Question: Can a positive COVID-19 test qualify a beneficiary (including a beneficiary who is currently receiving non-skilled services in a nursing home?) for a covered Medicare Part A skilled nursing facility stay?

Answer: A COVID-19 diagnosis would not in and of itself automatically serve to qualify a beneficiary for coverage under the Medicare Part A SNF benefit. That's because SNF coverage isn't based on particular

Continued next page

diagnoses or medical conditions, but rather on whether the beneficiary meets the statutorily prescribed SNF level of care definition of needing and receiving skilled services on a daily basis which, as a practical matter, can only be provided in a SNF on an inpatient basis.

HHI feels that the above CMS answer does not disallow skilling COVID-19 patients as the caller stated. The answer does assume the inquirer understands the Practical Matter Criterion. With that said, we need to unpack it.

5. Practical matter criterion

The practical matter criterion is a principle used in decision-making to determine whether an action or decision is practical and able to be carried out in the real world. It is used to assess the feasibility and likelihood of success of a proposed plan or idea, and to ensure that resources and constraints are considered. The intent of the practical matter criterion is to help ensure that decisions are realistic and achievable, rather than being based on idealistic or unrealistic assumptions. The Practical Matter Criterion is used to ensure that the patient is not receiving services that can be provided in a less intensive setting, such as at home or in a community-based facility.

"As a practical matter, considering economy and efficiency, the daily skilled services can only be provided in a skilled nursing facility?"

It is appropriate to skill a patient when:

- Outpatient services are not available in the area where the individual lives.
- Outpatient services are available in the area where the individual lives, but transportation to the closest facility could cause an excessive physical hardship, be less economical, or less effective than placement in the skilled nursing facility.
- The availability at home of a capable and willing caregiver should be considered, but the care can be furnished only in the skilled nursing facility if home care would be ineffective because there would be insufficient assistance at home for the patient/resident to reside there safely.
- If the use of alternative services would adversely affect the patient/resident's medical condition, then as a practical matter the daily skilled service(s) can only be provided on an inpatient basis.

6. COVID-19 diagnosis and presumption of coverage criterion

Per the CMS response above, "A COVID-19 diagnosis alone does not in itself automatically qualify" is not that simple. And it is recommended that providers utilize experts in the field of Medicare Skilled Coverage Criterion when they are unsure or encounter interfacility disagreement on a coverage decision. HHI agrees and applies the principle that every case needs to be reviewed individually and that multiple factors (diagnosis, functional level, medical conditions, comorbidities, presumption of coverage, practical matter criterion, etc.) all impact the decision for skilled coverage.

HHI highlights the importance of understanding, considering and referencing the Presumption of Coverage Criterion. An isolated COVID-19 positive patient codes into an ES1 Nursing Case Mix Group (CMG) which is in fact supported by the Presumption of Coverage Criterion. As a review, the PDPM CMG (Case Mix Group) is a classification system used in Skilled Nursing Facilities (SNFs) to determine the level of care and reimbursement rate for Medicare patients. The Nursing CMG level is determined by the patient's clinical condition, care needs, diagnosis, and approximately 103 plus elements from the MDS. The PDPM CMG (Case Mix Group) level is used in conjunction with the Presumption of Coverage Criterion, also known as the Skilled Coverage Criterion, to determine the patient's coverage under Medicare's SNF benefit.

The Presumption of Coverage Criterion "automatically classified as meeting the SNF level of care requirement i.e., skilled up to and including the assessment reference date (ARD)."

The SNF PPS Final Rule directs providers that a Medicare beneficiary is essentially skilled if the 5-Day PPS MDS Assessment is accurately coded and classifies the patient into one of the upper 17 Nursing CMGs.

The Upper 17 Nursing CMG's Presumed Skilled:

1. ES1 (COVID-19-positive and Isolation)
2. ES2
3. ES3
4. HDE2
5. HBC2
6. HDE1
7. HBC1
8. LDE2
9. LBC2
10. LDE1
11. LBC1
12. CDE2
13. CBC2
14. CA2
15. CDE1
16. CBC1
17. CA1

Medicare Beneficiary is not automatically skilled if the 5-Day PPS MDS Assessment is accurately coded and classifies the patient into one of the lower 8 Nursing CMGs. However, a lower 8 CMG does not mean the patient does not qualify for skilled coverage. The Lower 8 Nursing CMG's NOT automatically Presumed Skilled (and more likely to be audited by MAC), but can be skilled:

1. PDE2
2. PBC2
3. PA2
4. PDE1
5. PBC1
6. PA1
7. BAB2
8. BAB1

Per the FY 2019 SNF PPS Final Rule, the purpose of the presumption is "to afford a streamlined and simplified administrative procedure for readily identifying those Beneficiaries with the greatest likelihood of meeting the level of care criteria ..."

The administrative presumption whereby a Medicare Part A Beneficiary who is correctly assigned to one of the designated, more intensive Case Mix classifiers on the initial 5-Day Medicare PPS Assessment is automatically presumed skilled.

7. Be kind and courteous

Please stay positive! It is much easier to be negative and to not pause to dissect the rules. The long-term industry needs advocates and thinkers to keep this industry afloat. Please be mindful and intentional about being part of the solution.

"An open mind is not an end in itself but a means to the end of finding truth." - Peter Kreeft

8. HHI is here to help

This article demonstrates the complexity of the Medicare reimbursement system. The intent is for providers to make proper decisions with all the facts of Medicare Entitlement, Eligibility and Coverage Criterion. If you do not know or need to ask a question, HHI is here to help. HHI provides definitive coverage decisions only when a medical record review is completed.

Kris Mastrangelo, OTR, MBA, NHA, is president and CEO of Harmony Healthcare International and is a nationally-recognized authority of Medicare issues. She is a regular contributer to the New England Administrator.
Contact Kris : 800-530-4413. harmony-healthcare.com.

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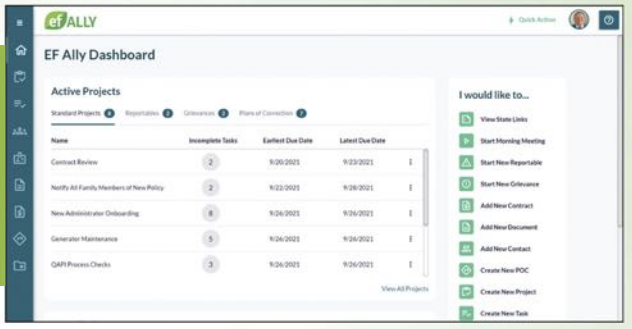

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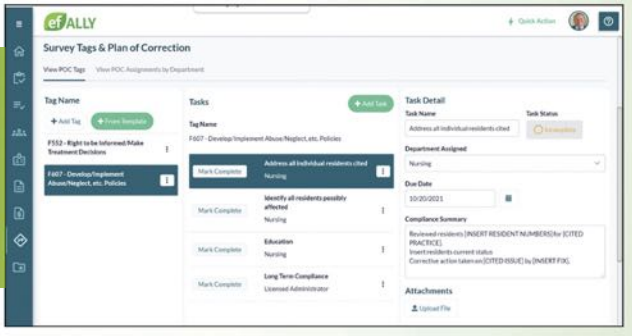

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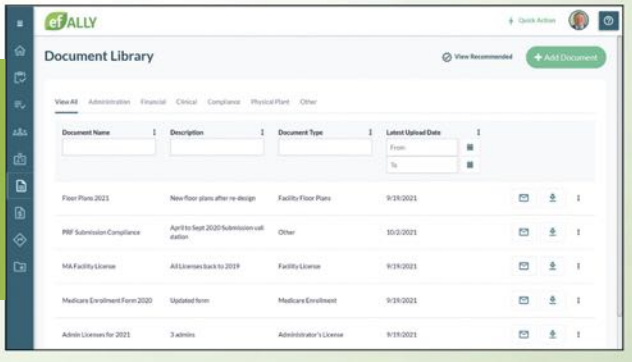

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The Marketing Guru: Are we at or near a critical juncture?

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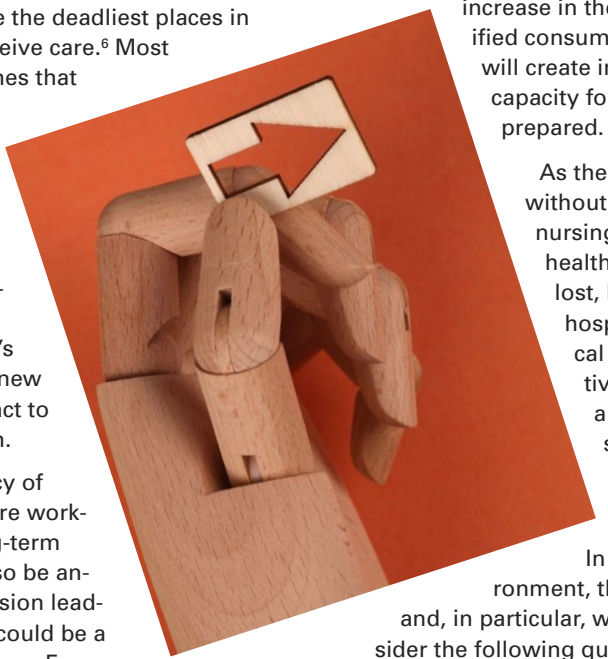
quacy (demographic, immigration, status, and economics) toward less relevant planning topics. One of the critical ingredients to critical junctures (apologies for the play on words) is a widespread acknowledgment that the current institutions aren't working, and that the publicly identified and acknowledged problem is intractable by the solutions at hand.

The health and social care "systems" in the United States are so extraordinarily fragmented that few understand how to navigate them. So-called cross continuum collaborations are local, uphill battles.[5] Among the best (disruptive) outcomes for nursing homes would be to become fully, federally integrated with other healthcare and social care providers in the US healthcare "system." This would require a harmonization and rationalization of regulations and legislation, which would truly be disruptive.

Another fundamental fracture in the aging services infrastructure in the US is where care occurs. There are generally two venues: institutions (nursing homes and hospitals) and; home. The latter might be an apartment, standalone house, or even an assisted or independent living residence. The public has finally become aware that hospitals are the deadliest places in which to receive care.[6] Most nursing homes that were built before the era of certificate-of-need requirements are decades-old and decrepit. What's needed is a new Hill-Burton act to rebuild them.



Inadequacy of the direct care workforce in long-term care may also be another dimension leading to what could be a critical juncture. For decades, the inadequacy of the direct care workforce for the imminent search in age-qualified demand has been recognized. The political fixes include depoliticizing regulations around nurse qualifications and bringing back nurse and caregiver visas. Such changes would increase the supply, while relying very heavily upon established institutions to monitor quality and outcomes. The underlying demographics is like the looming, biggest part of an iceberg beneath the surface of public attention.

What if we lost 30% capacity?

Inadequate workforce in both institutional and home-based care, changed behaviors among consumers, increasingly profiteering intermediaries, slow adoption of technological efficiencies, and inflationary pressures are forcing nursing homes to close, and home health agencies to delay, ration or decline starting services. While home care agencies are more supply-and-demand elastic, nursing homes in particular are having a hard time, with many of them on the brink of fiscal collapse (known as "zombies"). If the current political, economic, social, and legal quagmire isn't enough to bring the sector in the US to a critical juncture, would losing 10, 20 or 30% of our capacity precipitate real change?

Even if the capacity remains as is, by 2040, by back-of-the-envelope estimates, the US will be short 3,000 to 4,000 nursing home beds, and unable to staff 6,000 to 8,000 home care visits. Significant increase in the number of age-qualified consumers starting in 2030 will create increased demand for capacity for which the US is unprepared.

As the situation evolves without major change, more nursing home and home health agency capacity is lost, leading to backed up hospitals, negative political attention, more punitive media attention, and regulatory pressure.

Change in the social contract

In considering this environment, the crisis we are in, and, in particular, what's possible, consider the following questions as we look a bit farther down the road:

- Will baby boomers' children (Generation X and millennials) accept the maddeningly complicated, fractured means of supplying long-term care to their aging boomer parents?
- Will they tolerate the erosion of their inheritance, the largest inter-generational wealth transfer in history, to pay for long-term care?
- How will Xers and millennials respond to declining/ unavailable/inadequate/unacceptable supply as they attempt to find support services in this extraordinarily complex institutional environment

While we may not be at a critical juncture, the signs of the crisis are all around us and even bigger challenges are looming just around the corner. In the past, changes in the social contract, such as the Social Security amendments of 1965, have occurred as a critical juncture to create new capacity. Those of us working in the sector, while navigating incremental change must be alert with policy alternatives when the opportunity arises for a new social contract in long-term care.

[1] If the reader would like to go over some of these precipitating factors, please see: Fatal Contraction: Healthcare Adjusts to a Shrinking LTC Sector, https://bit.ly/3iNb6e0.

[2] Sorensen, A. Taking critical junctures seriously: theory and method for causal analysis of rapid institutional change, Planning Perspectives. 2022

[3] David, "Clio and the Economics of QWERTY"; Pearson, Politics and Time

[4] https://www.ssa.gov/policy/docs/ssb/v28n9/v28n9p3.pdf

[5] See: Bridging the Divide: Transitions to Cross-Continuum Collaborations in Healthcare https://stackpoleassociates.com/transitions-cross-continuum-collaborations-healthcare/

[6] The pandemic has raised public awareness regarding the rapid rate of contagion within all institutions, hospitals included. The public seems generally unaware, however that iatrogenic deaths in hospitals are routinely over 200,000 per year making hospitals far deadlier by almost any measure than nursing homes.

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Industry reforms

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but a setup for failure. There is very limited information about the proposed mandate available to the public as of now. The last update from CMS consisted of an announcement that they held listening sessions with the general public in August 2022.

Special Focus Facilities

As part of the goal of enhancing accountability and oversight, the administration also announced an intention to overhaul the Special Focus Facilities (SFF) program. Before the proposed reforms, the program consisted of oversight over the poorest performing nursing homes in the country through increased inspections. However, President Biden called for more action.

On October 21, 2022, CMS announced new actions to strengthen accountability in the program. First, CMS will begin using escalating penalties for violations. Additionally, any facility with successive citations for dangerous violations risks possible termination from Medicare and/or Medicaid funding. Second, even if a facility fulfills all requirements to "graduate" from the program, CMS will continue monitoring the facility for at least three (3) years to ensure continued compliance with safety requirements. Finally, CMS will provide more outreach including a teleconference meeting with the nursing home's accountable parties to explain the SFF program and steps necessary to "graduate" from the program.

Transparency of nursing facility ownership

Finally, in an effort to increase transparency in the industry, President Biden announced an initiative to release data on facility ownership and financing. In September 2022, CMS publicly released data on the ownership of approximately 15,000 nursing homes certified as Medicare Skilled Nursing Facilities. Additionally, in December 2022, CMS released information on the ownership of more than 7,000 hospitals certified to participate in the Medicare program. This is the first time this information has been made publicly available, other than what may be gleaned from other resources.

The reforms spotlighted in this article are only a handful of the many changes that have been implemented in the past year. Although the Biden administration announced its intention to significantly improve the American nursing home industry roughly a year ago, actionable reforms and guidelines to achieve their three basic goals continue to be announced gradually. Biden declared an intention to continue cracking down on the industry in his 2023 State of the Union address. A close monitoring of the announced (and unannounced) initiatives in the coming years, as well as continued attention on the need for additional reimbursements, will be necessary to determine the impact the proposed reforms will have on the nursing home industry.

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Ornstein: Anxiety, worry and aging

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signs of anxiety and worry.

- What are the events in your day to day activities that are worrisome such as a loved one who has recently passed away and how I am coping with the loss?
- What is your most common worry and how do you deal with it–insufficient funds to pay my bills, an ill loved one living a great distance away, persistent loneliness that extends beyond my daily responsibilities, etc.?
- What issues have recently been encountered that have caused, what research scientists call "an emotional loss of control" such as dealing with a serious medical problem and being unable to obtain a clear direction or advice from medical professionals and related agencies?
- How do you envision the years ahead and what can you do to make them more satisfying and productive? With my advanced age, it can be very upsetting. However, I am considering volunteering at the local hospital, doing some bicycling, joining a senior citizens club, doing a little traveling to relatives and friends and see how they are getting along. But above all, make new friends of my generation, whether at religious or social venues.

Quotable Quote

"Make happy those who are near and those who are far will come."
- Lao Tzu.

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 NEW ENGLAND ALLIANCE

UPCOMING EVENTS

Fall Regional Conference at the Portland Regency Hotel & Spa
September 20 to 22, 2023

EDITORIAL

The Feds finally get it right

by Bruce Glass, MBA, FACHCA

In February, CMS proposed a rule that would significantly increase transparency in nursing home ownership.

Unfortunately, for too long, too many states have failed in their responsibility to vet change of ownership applications. The result has been a rash of complaints against many of these new companies. When stories of "bad operators" surface, it is a black eye for every conscientious owner, as care declines for many formerly excellent homes.

If the media focused more on the failure of regulators rather than tales of neglectful operators, this action would have occurred long ago. Now, at last, CMS apparently is taking this critical step. For once we are on the same team.

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

Talking dirty

Continued from page 14

She finally snapped she said, after watching everyone walk past the food truck for more than 30 minutes. That's when she spoke up, asking to talk to a manager. There wasn't any.

This is where it got interesting. She asked each of us if we knew there was a staffing shortage. We all nodded, trying not to smile and eager to tell her that is exactly why she saw the things she did. She nodded along with us, as if she agreed. Then she stood up.

"Everywhere I look, I am reminded there is a staffing shortage," she said. "It's on the news almost every night. It's in the papers, and on the radio. Everyone knows there is a staffing crisis, that people are burned out and don't want to work, and the elderly are suffering. Yet there wasn't a single

manager in this building until 8:30am."

She continued to look around the room, scanning each of our faces, looking for some recognition of ownership. But she didn't find it.

"I wish I could take my mother out of here," she said and left.

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

DIVERSITY, EQUITY & INCLUSION

The American College of Health Care Administrators values and seeks to advance and promote diverse and inclusive participation within the organization regardless of gender, race, ethnicity, religion, age, sexual orientation, gender identity and expression, national origin, or disability.

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ACHCA members, if you have questions on how to GET INVOLVED, contact any committee member!

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