

New England ADMINISTRATOR

June
2022

"Always do right. This will gratify some people and astonish the rest."
-Mark Twain



District One

ACHCA

American College of
Health Care Administrators

New Hampshire leads the way in staffing

Welcome Bienvenue



New Hampshire

HIRE STAFF (OR DIE TRYING)

IN THIS ISSUE:

Pain, comfort, and aging • The Tyrannosaurus Rex of nursing home chains
The C.A.R.E.S. Expert • The Marketing Guru • Talking Dirty



HHI C.A.R.E.S. About Care

Compliance • Audit/Analysis • Reimbursement/Regulatory/Rehabilitation • Education/Efficiency • Survey

Documentation Review | Revenue and Risk Analysis
 Mock Survey (Mock Audit, Health Inspection, Medicare & Medicaid)
 PDPM, MDS & Case Mix Audits | MDS, Medicare & PDPM Trainings | Plan of Corrections
 Infection Control Audit & Training | Five Star Analysis (Survey, Staffing/PBJ & Quality Measures)

617-595-6032 • info@harmony-healthcare.com • www.harmony-healthcare.com

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

Medicare medical record reviews and appeals process: Five levels of appeal

by Kris Mastrangelo,
OTR/L, MBA, LNHA

The healthcare industry is experiencing a significant increase in Medicare Part A and Medicare Part B (Fee for Service) Medical Record Reviews by The Centers for Medicare and Medicaid Services (CMS). Typically, the process begins with an Additional Development Request (ADR) or a Targeted Probe and Education (TPE) seeking portions of the medical record that supports the rationale for skilled services under the Medicare Part A and Medicare Part B Insurance benefit.

The Centers for Medicare and Medicaid Services (CMS) contracts with Medicare Administrative Contractors (MACs) to assist with local claims processing and to review the first level appeals adjudication functions.

These Medical Record Reviews are prompted by an item on the UB-04, specific to the patient, such as the: HIPPS Code, ICD-10 Code, RUG Level, and Dates of Service. In these cases, the health care provider may receive requests for a few patients, in the range of two to five claims per provider.

Other times, the Medical Record Reviews may be part of a widely diffused request for items from the medical record to discover information about the billing practices or patterns of an organization. These types of reviews are known as "Probe Reviews" in which MACs may assess 20 to 40 claims per provider for "provider-specific" issues.

MACs also perform widespread probe reviews including around 100 claims per provider. These types of audits are triggered when there is a perceived outlier in the



provider's billing practice, such as an abrupt, sharp increase in billing for a specific procedure.

Although it is customary for providers to receive requests from MACs, providers need to pay close attention to these requests and ensure that there is an effective system in place to track timeliness and accuracy of the data submission. Even when providers submit all the requested data, it is not uncommon for the MAC to deny a portion of, if not the entire claim.

When any part of a claim is denied, the provider has the right to petition a second opinion. The appellant is the individual filing the appeal. (For procedures for conducting appeals of claims in Traditional Medicare, i.e., Medicare Part A and Part B, see Section 1869 of the Social Security Act and 42 C.F.R. Part 405 Subpart I.)

The claim appeals process has five levels:

- Level 1: Redetermination by a CMS contractor (carrier, fiscal intermediary or Medicare Administrative Contractor (MAC)).
- Level 2: Reconsideration by a Qualified Independent Contractor (QIC).
- Level 3: Hearings before an Administrative Law Judge (ALJ) within the Office of Medicare Hearings and Appeals in the Department of Health and Human Services.



PROCARE^{LTC}
Long Term Care Pharmacy Services

ADDRESSING THE PHARMACY NEEDS OF SENIOR CARE FACILITIES WITH LOW COST – HIGH QUALITY PHARMACY SERVICES!

- Low Cost Provider!
- Timely Delivery!
- Interfaced with most EMR systems!
- Electronic Billing!
- Monthly Customer Service Meetings!
- Newest Technologies available!
- Facility Education & Support!
- Survey Prep and support from experts!

Contact: John Enos (508) 439-9330 / jenos@procareltc.com

- Level 4: Review by the Appeals Council within the Department Appeals Board in the Department of Health and Human Services.
- Level 5: Judicial Review in federal district court.

Further relevant details on requesting appeals, for each of the five levels, is summarized below.

Redetermination (First Level of Appeal) Form CMS-20027

For the First Level of Appeal (traditional), the MAC is involved in deciding the results of the redetermination. The appellant (the individual filing the appeal) must file the request for redetermination with the contractor within 120 days from the date of receipt of the initial determination. The appellant should attach any supporting documentation to their redetermination request. Note: If a claim contains a minor error or omission, the claim may be corrected through the

reopening process rather than the appeals process.

The request for a redetermination may be filed on Form CMS-20027.

Response:

- The initial determination is the Medicare Summary Notice (MSN) issued to

Continued on page 16



Kris Mastrangelo

Responding to the staffing crisis

by Irving L. Stackpole, RRT, MEd

The US is in the midst of a crippling long-term care staffing crisis. The crisis is so severe, that people in need of care are not getting what they need, when they need it, in suitable quality or amount. This dire situation is having severe, even existential effects on many providers, especially skilled nursing facilities (SNFs) where the constraints are severe.

Not enough workers and not enough money

There are not enough available and/or qualified individuals to fill the vacant long-term care staffing positions. Because of demand (patients needing service) and regulatory constraints, home care agencies and nursing centers have been "chasing" available personnel, with economically severe consequences.

"In Florida, long-term care facilities' use of employment agencies is up by nearly 300%," according to the Florida Health Care Association. "Facilities have seen an increase of \$275 million annually in staffing costs resulting from paying overtime, contract labor,

and other costs associated with hiring additional in-house staff..." This crisis is not a sustainable scenario.

Attention has been drawn to the inadequate pay for front-line care workers, especially for certified nursing assistants (CNA's). The logic goes, "pay frontline workers more, and providers will attract more workers to these jobs." In normal circumstances, these hydraulics function normally. Current markets are hardly "normal." There is no evidence that there are enough people to fill the vacant positions, or that offering them more money would attract enough candidates to fill the vacant positions.

Part of the issue is that other healthcare and social care settings are attracting employees from residential and nursing center jobs.

Increasing compensation for those who are already working in long-term care may stem the exodus, but it will only have a modest effect on attracting those who have left to return to

these jobs. There may not be enough people on the sidelines, who are not currently working, and who could be attracted to take these roles, to make much of a difference to the shortages in long-term care. Competitive compensation

Before the pandemic, more

than 17% of CNA's lived at or below the Federal Poverty Level (FPL), twice the national average of people living in poverty (9%). The national average wage for a CNA, \$14.37 is below the minimum wage level being promulgated by several states (\$15 per hour) and a few states are pushing for \$20.00 / hour Medicaid wage for CNA's. Is a higher hourly wage the "fix"? Probably not. In a national job market with 3.6% unemployment and high workforce participation, the employers that attracted away the long-term care workforce will simply not roll over and let them leave without offering them something more. And Medicaid is not, nor is it likely to ever be a sole, sustainable economic model for long-term care providers. The sector needs far broader, smarter and more extensive solutions.

Truly competitive compensation is not adding a few dollars per hour. The long-term care



Accounting

Billing

MassHealth Applications



Our specialists may provide services on an interim to long term basis; or train your staff.

Visit our website for our brochure

www.OriolFinancial.com

Professional financial assistance & problem solving



Irving L. Stackpole





STARKWEATHER & SHEPLEY

HEALTHCARE RISK SOLUTIONS

Specialist in insurance, risk management,
and related services to
eldercare communities...



Matthew Paris
Healthcare Practice Leader
401-435-3600 x1625
MParis@starshep.com

Brian Zartarian
Account Executive
401-435-3600 x1362
BZartarian@starshep.com

Starshep.com

New Hampshire needs caregivers—and is doing something about it

by KR Kaffenberger, PhD

IN NEW HAMPSHIRE, regulations combine registration for nursing assistants working in nursing facilities (LNAs) and those working in home health care (HHA). The certification, licensed nursing assistant (LNA), qualifies workers in both settings and in other health settings. The training which is required is one of the more thorough in New England and in the United States. A minimum of 100 hours of training, including 60 hours of clinical training, is needed to become a licensed nursing assistant.

New Hampshire, like many states, has a significant deficit in the numbers of direct care workers available in health care generally and long-term care more specifically. Unfortunately pay for direct care workers had not changed. New Hampshire is the only New England state not to make some Medicaid rate adjustment for direct care workers in nursing home settings during the Covid-19 pandemic. There is progress regarding rates as Senate Bill 412 has passed the New Hampshire Senate and will provide some rate relief for New Hampshire nursing facilities.

As in other states, the pandemic made work in nursing home settings more demanding and less rewarding in many ways. It also increased competition for labor and especially direct care workers. Some nursing homes are reported to be paying experienced LNAs as much as \$20 per hour.

The pandemic has affected the availability of direct care workers in home health and assisted living as well as in nursing facilities. It is predicted that the pandemic effect on shortage on workers may recover by 2024. However, there is a secular trend of loss of direct care workforce in New Hampshire even as the number of persons needing direct care has increased and is predicted to increase further. According to the Economic Labor Market Information Bureau of the New Hampshire Bureau of Employment Security, "It is among prime age workers (25-54) where industries serving older adults have shrunk most." Recorded job openings in these fields have about doubled since 2019.

One answer to the ongoing direct care worker shortage is the "New Hampshire Needs Caregivers Program." The grant-funded program was developed in 2019 through Civil Monetary Penalty (CMP) funds levied on nursing homes. The program recruits candidates who wish to become

LNAs in New Hampshire and provides them with the information and funds to enter a program and also helps with placement. Its graduates work in long term care facilities.

LNA training in New Hampshire costs about \$2000. New Hampshire Needs Caregivers assists recruits to find funding to cover the cost of training and attempts to find interim employment for recruits while they train. It partners with several facilities that become a source both of interim employment and eventual placement. The program is constantly recruiting partners as well as caregiver (LNA) applicants.

There are a many different sources of funding for trainees. Medicaid-eligible displaced workers will have their training costs fully covered. There are several charitable and government organizations that are prepared to make grants for caregiver training through New Hampshire Needs Caregivers. LNA graduates who obtain employment in licensed nursing facilities may submit the Application for Financial Reimbursement for Nursing Assistant Training and Competency Training to the New Hampshire Bureau of Elderly and Adult Services for full reimbursement. LNA graduates who are part of the program may receive a \$500 bonus after six months of employment at a participating New Hampshire Needs Caregivers facility or organization.

Lynn Carpenter, program director of New Hampshire Needs Caregivers, is pleased with the program in many ways. By October 2021 about 1400 individuals made inquiries about the program and almost one in four of them entered the program and either became LNAs or are in the process. However, Carpenter points out that in an earlier period (March 2019 to February 2020) about 571 licenses were lost. It is unknown how many current LNAs are not working in the field. It is also uncertain how many may return after the pandemic crisis passes. Funding under this program ended in 2021. While Carpenter is pleased with the program, she can see that more is needed.



KR Kaffenberger



The Centers for Disease Control and Prevention provided additional funding. The program is now operating with these funds. It may provide an opportunity for broader participation of healthcare facilities and organizations, including assisted living facilities, home health agencies, and hospitals.

In addition, Carpenter, Roxie Severance, and others are turning toward high schools and extended learning opportunity coordinators to open an additional avenue for LNA recruitment, training, and employment through the "NH Needs Caregivers Healthcare Heroes in the Making" program. This is now being run as a pilot program with support from the Governor's Office for Emergency Relief and Recovery through December of 2022.

All the New England states have some free training for CNAs and similar caregivers. Most of these programs are offered by facilities that use CNAs or LNAs in their operations. State nursing boards and employment offices often provide lists of places where training may be obtained free or by paying tuition. Notably, Cambridge, Massachusetts and Burlington, Vermont maintain free training programs.

However, it seems that New Hampshire Needs Caregivers and its developing activities is the only non-provider organization in New England designed to aggressively recruit, assist, and mentor men and women who wish to enter the direct care field. The needs of the various states are somewhat similar. The answer that New Hampshire has found in New Hampshire Needs Caregivers may be one that could be emulated in other states to everyone's benefit.

K.R. Kaffenberger, PhD is an Instructor of Gerontology at UMass Boston and a former nursing home owner in Massachusetts.

Giving Care: A strategic plan to expand and support New Hampshire's health care workforce –Excerpts from the state plan

by Roxie Severance, CNHA, FACHCA

Prior to the pandemic, New Hampshire was the second hardest hit state by labor shortages. One example is the chart included here. LNA licensure data from NH board of nursing shows there was a net loss of 571 LNAs, in the year prior to the pandemic.

The Giving Care report states that between 2017 and 2019, the state's health care workforce was the fastest growing sector with the most unfilled jobs. As with most states the aging of the workforce and the pandemic fueled departures from the healthcare field. Also reported is that the health care sector, because of its size and rate of growth, is critical to the state's overall economy. In addition, even more urgency to address the existing workforce crisis is that New Hampshire's health care "bench" is not deep enough and lacks diversity sufficient to meet the needs of the state's increasingly diverse population.

In 2020, the Endowment for Health's Forward Fund stakeholder group convened over 50 leaders to discuss strengthening New Hampshire's healthcare workforce by creating synergy among the many existing workforce initiatives, sharing lessons learned, identifying barriers, gaps and needs. Along with this meeting, the Endowment for Health engaged the state's Community Health Institute/JSI Research & Training Institute to facilitate the development of an actionable (two-year) Statewide Health Care Workforce Strategic Plan. More than 70 stakeholders representing virtually every type of provider, educator, policy maker, regulator, labor specialists, and employers met in began the process designing a statewide

workforce plan with actionable strategies. The group early on identified four key areas for action: pipeline, recruitment and retention, policy and regulation, data collection and governance.

The four work groups met to discuss barriers and challenges that impacted the health care workforce. Low wages, high cost of living, reimbursement issues, thin pipeline, policies, siloed workforce efforts,

Hampshire's health care workforce development and spent a lot of time discussing the need for public-private partnerships. All workforce groups agreed that resource identification was critical to a successful plan implementation.



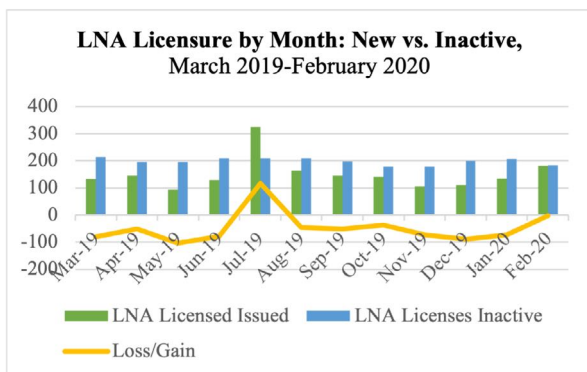
Roxie Severance

Month/Year	LNA Licenses Issued	LNA Licenses Inactive	Loss/Gain
19-Mar	133	214	-81
19-Apr	146	197	-51
19-May	93	197	-104
19-Jun	129	208	-79
19-Jul	325	209	116
19-Aug	163	209	-46
19-Sep	146	198	-52
19-Oct	141	178	-37
19-Nov	105	178	-73
19-Dec	111	200	-89
20-Jan	134	207	-73
20-Feb	182	184	-2
Total			-571

As the Healthcare Sector Advisor, I served on three of the four workgroups. I can attest that the process was good, and all views were heard. Since the convening of DHHS, Commissioner Lori Shibinette's Roundtable meeting, the Endowment for Health has been meeting with workforce groups and others to review the plan. Yvonne Goldsberry, president of the Endowment for Health, believes that there is a role for all in implement Giving Care. She says whether employer, policymaker, government official, educator, or advocate, it will take all of us working together to implement the plan.

I agree with Yvonne. Further, I believe that cooperation (co-op-e-tion - /k əp tiSH(ə)n/ - noun - collaboration between business competitors, in the hope of mutually beneficial results) is the only answer. Long-term care employers need to get out of their "crisis" mode and find creative ways to work together to produce a robust workforce by partnering with their competitors on a wide variety of programs like registered apprenticeship, NH Needs Caregivers, and other workforce initiatives.

One suggestion is that employers should read the Giving Care document and determine where they fit in. What initiatives are working for them that they can share? Another suggestion is to join one of five regional healthcare workforce groups that convene each month in NH. The healthcare workforce shortages can be solved by building upon the many existing healthcare workforce initiatives, like the Sector Partnership Initiative (SPI). SPI meets regionally around the state each month to collectively grow the healthcare workforce. For more information about joining one of these groups, contact Roxie Severance at roxie@rsconsulting.services.



and lack of data were a few of the discussion points that led to the formation of the state plan that was released on April 18, 2022 at the Commissioner's Roundtable Meeting.

It was important to all participants that this plan would not sit on a shelf and gather dust. As a result, 16 objectives and 107 actionable strategies were developed. The pipeline, recruitment and retention workgroup wanted to ensure a current and future supply of qualified workers were available to meet the needs of the state's residents. The policy/regulatory workgroup honed-in on reducing regulatory constraints and advancing policies that support a workforce capable of meeting the health care needs of residents. Ensuring that sufficient data infrastructure, processes, and resources exist to identify and address workforce gaps and trends as well as issues affecting pipeline, recruitment and retention was the focus of the data

workforce group. The governance group felt there was a need to ensure capacity for the study, coordination and oversight of New

Pain, comfort, and aging

by Sheldon Ornstein Ed.D, RN,
LNHA

By definition, comfort is “a state of ease and satisfaction, of bodily freedom from pain and anxiety.” According to recent research, “the absence of physical pain is not always sufficient to provide comfort. The aged may have their biologic needs satisfied but still be emotionally distressed.”

Nurses understand the significance of the word “comfort” which describes the goals and outcomes that aid in determining the nursing measures needed to administer care. However, the meaning remains vague and essentially abstract to the person who is the recipient of that nursing intervention. The researcher, Hamilton, studied the meaning and attributes of comfort from the point of view of the chronically ill elderly who is hospitalized in a geriatric setting. Hamilton’s definition of comfort is “multidimensional, and means many things to different people.” The researcher, McCaffery’s definition of pain is “whatever the person experiencing pain says it is.”

Pain, whatever its source, erodes personality, saps energy, and foments anguish until that cycle is broken. It is important to realize that an individual responds in a certain way to pain. Young and old have been taught as children that this is “correct and normal.” Likewise, nurses and caregivers are likely to respond in a certain way based on their own pain experiences and what may have been taught in their nursing programs and even in family life. Pain tends to weaken and interrupt the elderly individual’s idea of their relationship to self, others and their environment. In the aged, fear and anxiety can generate negative effects that emanate

from thoughts that pain will result in crippling and forced dependency or that it will be of such intensity that the ability to cope will be inadequate.

The elderly are at high risk for pain inducing situations. The following are several myths and facts about pain in the aged:

Myth: Pain is always expected with aging.

Fact: Pain is not normal with aging. The presence or absence of pain in the elderly would however necessitate a diagnosis and physical assessment to demonstrate otherwise.

Myth: An elderly person who has no functional impairment and appears occupied or distracted from that pain must not have significant pain to begin with.

Fact: The elderly may have a variety of reactions to pain. Many are stoic and refuse to “give in” to the pain. Over an extended period, they may also mask any outward signs of pain.

Myth: Pain sensitivity and the individual’s perception decreases with aging.

Fact: Data regarding age associated changes in pain perception must be demonstrated via observation of needless suffering, proof of under-treatment and an underlying cause.

- To better understand the elderly’s pain, I recommend certain questions that can be asked to address the underlying causes. By using these questions, the nurse or caregiver can obtain a clearer idea of what the origin of the pain might be:



- Are you concerned about the pain sensation itself or about the implications of what the pain can produce?
- Are you afraid of what the pain may mean such as a sign of a serious illness? Can it deprive you of specific pleasures or a physical activity you had been enjoying?
- Do you want to be alone for fear of showing an unwanted emotional response that can be interpreted as a weakness?
- Do you want visitors to “share” your discomfort or rely on visitors only as a distraction?

One cold wintry morning I was asked to visit a resident, John, who wanted to talk about an issue that was disturbing him. Here then is his experience with pain and how he was dealing with it.

“When in agonizing pain and you lie at death’s door, praying to pass through it and it closes in your face, you realize there must be some reason you are ignored. Gathering strength for the struggle to recover, you find comfort in even small increments of strength and satisfaction in the tiniest improvement,” John told me.

Unfortunately, his pain was caused by a malignancy that would eventually end his life. However, in the time he was with us, he was under the care of a competent hospice staff. As the end drew near, John expressed his thanks to everyone for their kindness and excellent treatment, but most of all, for

the lessening of his pain. The nurses who were involved with John’s care were influential and meaningful in their concern for him.

Although this article does not discuss the various pain-alleviating practices and interventions, it would be expected that the doctors, nurses, therapists, etc. providing care would have knowledge of the physiologic aspects of pain and the practices that are accepted as treatment by the medical community. Some examples would be meditation, transient cutaneous nerve stimulation (TENS), massage, imagery, hypnosis, placebo, and pharmacologic pain control.

Lastly, to those caring for an elderly individual with intractable pain, you need not look upon the pain with fear or trepidation. If the assessment is medically correct and the individual who is suffering is listened to, and the case is handled gently and wisely, the anxiety can be controlled. The intervention, whatever it may be, will prove effective to the resident’s satisfaction, and you can be further assured that the care you render will bolster confidence with others who may also seek your guidance for that which is causing their discomfort.

Quotable Quote
“One act of kindness can change the world.”

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.

PIONEERS & ROGUES: Beverly Enterprise

We regularly feature a New England individual whose accomplishments—good or bad—helped to shape our profession. In this issue, we instead highlight a chain.

The Tyrannosaurus Rex of nursing home chains

by Al Terego, special correspondent to
The New England Administrator

Almost everyone is familiar with the dinosaur Tyrannosaurus Rex, which is a Latin name for “Tyrant Lizard King.” The T-Rex was a predator and scavenger with an insatiable appetite, a colossal and fierce presence during its reign on earth that was rarely challenged by other species.

Although it has been some 65 million years since the last dinosaurs roamed the earth, we are still fascinated with the mysteries surrounding their extinction, and still in awe of their sheer size and raw strength.

Many futurists predict that nursing homes will disappear one day, and that we are merely dinosaurs of a bygone era of health care, unable to evolve to meet the changing demands of consumers and regulators, and just seeking to avoid extinction. If nursing homes are to be compared with dinosaurs, there is one organization that has earned the distinction of being the T-Rex of nursing home chains. The Tyrant Lizard King is none other than Beverly Enterprises, the largest nursing home company ever to exist.

Like the T-Rex, Beverly had an insatiable appetite for growth, with more than 1,300 nursing homes at its peak in the 1980s. Its nearest competitor had less than half as many.

Sifting through the fossils left behind, Beverly Enterprises had its beginnings in California in the early 1960s and grew steadily to become a behemoth in 45 states, plus Canada and Japan, owning nursing homes, retirement centers, LTACHS, some hospices, and 65 pharmacies that made up the Pharmacy Corporation of America.

Beverly Enterprises grew aggressively in the 1980s, devouring small chains with solvency issues. It was said that Beverly executives would fly around the country seeking to purchase nursing homes, and if they smelled urine as they flew over, they would land to make an offer.

In some promising markets, they would invest heavily in the physical plant to attract a private pay clientele. Other buildings were left to languish. As the organization quickly grew, a mountain of debt of more than \$1 billion dollars left them scrambling to cut costs by centralizing many functions as well

as reducing staff to take advantage of economies of scale.

Inevitably, understaffing led to quality problems in one state after another. Poor state surveys in Maine, Washington D.C., California, Texas, Missouri, Minnesota, Michigan, Arkansas, Florida, and Hawaii, led to lawsuits and a declining reputation. In California, Beverly paid over \$1 million in fines for care deficiencies that resulted in the death of several residents.

Other states were even worse, including \$1.2 million for a racial discrimination suit in which they were found to be criminally neglectful, and over \$2 million in civil penalties. In three years, Beverly Enterprises lost \$160 million.

In 1989, under the direction of CEO David Banks, Beverly Enterprises reorganized its holdings, selling off many underperforming homes and vacating states where the litigious atmosphere made business difficult.

In Florida, for example, a personal injury lawyer named Jim Wilkes would park his RV across from a Beverly property, sometimes near one of his many billboard advertisements, and he would ask questions of staff and family members as they came and went, to uncover opportunities to sue. His knowledge of the innerworkings of Beverly Enterprises, their staffing patterns, problems, inspection reports and financial performance, astounded Beverly executives in their effort to combat his assaults. Ultimately, Beverly sold its Florida properties.

In all, Beverly sold 35% of its properties, and eliminated three layers of management. In 1990, Beverly Enterprises, now much leaner and focused, became a publicly traded company on the stock market.

Their reputation, however, had been badly compromised. Their tone-deaf timing of announcing record earnings to stockholders while newspapers and media simultaneously released reports on compromised care that resulted in bed sores, injuries, and deaths, ultimately cratered any remaining positive reputation they still had.

The CEO, David Banks, was paid \$2.6 mil-



The Norseland Nursing Home in Westby, Wisconsin was operated by Beverly Enterprises.

lion one year in the late 1990s. Other Beverly executives were also renumeralated handsomely, as the stocks rose, and quality declined. Some highly ranked executives left Beverly Enterprises but were passed over for other job opportunities because of their association with the company.

By the early 2000s, a new CEO, Bill Floyd, oversaw the final chapter of Beverly Enterprises. With 350 homes left in its portfolio, the company was eventually purchased by Golden Living Centers, and ceased being publicly traded.

An archeological dig of Beverly Enterprises reveals remnants of an organization whose reputation has become synonymous with poor care and quality, but that simple statement belies all the efforts of good staff members who toiled under exceedingly difficult conditions for a publicly traded corporate nursing home organization. It's an unfair characterization.

We, the members of ACHCA, understand the heart and soul necessary to work in this profession. Throughout the company, scores of staff members lovingly and compassionately cared for deserving residents. Well-meaning administrators tried to make it work, from resident and family satisfaction to inevitable staffing challenges, to regulatory compliance. Unfortunately, the goals of Beverly Enterprises were structured to comply around the satisfaction of shareholders more than anyone else.

The government gets it right (barely)

by Bruce Glass, MBA, FACHCA

For the first time in history, nursing homes made it to the State of the Union Address. But that is hardly good news, as the President lambasted homes for the covid deaths within their confines.

That, of course, should come as no surprise, as unfair as it is. A study by leading health-care experts exonerated the industry, but the truth matters little in politics. In this case, Biden yielded to pressure from AARP, which has long advocated severe financial penalties for every "deficiency"—no matter how minor.

Where he got it right was in urging more transparency in ownership. Too many times, inept or shady owners have been allowed to purchase

good homes and destroy them.

An example of this is Beverly Enterprises, the subject of an article in this issue.

However, there have been more recent examples. A New Jersey company, with only a token office in a strip mall, was allowed to purchase several Massachusetts homes—quickly leading to disastrous care and financial ruin.

This has happened all too often, not only in Massachusetts but also in neighboring states. It is the responsibility of states to prevent it by using a better vetting process.

On the federal level, legislation and/or regulation must prevent the opaque layers of ownership that too often hide the true villains in these cases.



All of us pay the price for those "bad apples" that taint our industry.

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.

CMPs

A civil monetary penalty (CMP) may be levied against a provider facility for not being in substantial compliance with requirements for participation in Medicare and Medicaid standards.

The funds thus collected may be used to improve facility (nursing home) care under a number of kinds of activities outlined by the Centers for Medicare and Medicaid Services (CMS). Qualifying organizations may apply for a portion of these funds to be used for an approved purpose. Application processes are determined state by state.

In 2020 Connecticut and Rhode Island were reported to have no CMP funded projects underway. Maine had two programs, and Massachusetts had one program providing staff education. New Hampshire had two programs: one for staff education and New Hampshire Needs Caregivers.



ARE YOU CYBERSECURE?

Healthcare is a top target for cybercriminals. And insurance companies are taking note -- demanding that healthcare organizations step up their security game or face steep rate hikes or worse, be declined coverage.

FULLY MANAGED FEATURES:



Multifactor
Authentication (MFA)



Email Security



Data Backup



Complete
Cybersecurity Solutions

For more info contact Matt Mello: Matt.Mello@fullymanaged.com
774-633-5851 | www.fullymanaged.com/solutions/senior-care



"YOU HAVE A PROBLEM," KIM SAID WHEN I WALKED INTO THE BUILDING. SHE WAS STANDING OUTSIDE MY OFFICE DOOR, WAITING.

"Good morning to you too," I said walking past her. I sat at my desk and took the lid off my coffee to let it cool down. Then I reached into a paper bag and took out a breakfast sandwich. I held it up.

"Want some?"

Kim said no but didn't move. She was still standing at the door with her head down, texting rapidly. She was a nurse manager. The kind of manager who demands to be involved in everything, but then complains that no one does anything unless she tells them to. I unwrapped my sandwich, took a bite and waited.

After a couple of minutes, Kim noticed the silence and looked up from her phone. I smiled, continued to chew, and again, offered her my sandwich. She rolled her eyes, annoyed, and sat down.

I shrugged and took another bite.

"What are you going to do about John?" she

said. I didn't know what she was talking about, plus my mouth was full, so I shrugged.

"Huh?"

Her phone buzzed.

"Damn it," she said, as she read the message. She started texting again—clearly agitated. I watched her for a minute and then took another bite of my sandwich. When she was done, she looked up.

"Okay, listen," she said and told me about the situation. John, a housekeeper who works for me, had apparently been dating one of her nurse aides and they had just broken up. Now that they weren't together, her aide was refusing to work on the

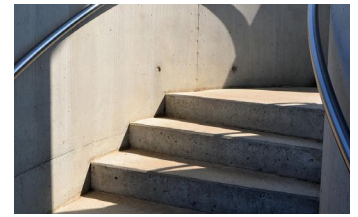
same unit as him.

I nodded and listened. "Interesting," I thought, but didn't say. Instead, I took another bite of my sandwich. Kim nearly exploded at this. She leaned forward and threw her hands in the air.

"Are you kidding me right now?" she said. "Stop eating and answer me!" I shrugged and chewed. Trying my best not to smile. Then I took a sip of coffee.

A few years ago, I attended a management training seminar and one of the speakers said managers should always take the stairs. Not out of some sort of martyrdom but because taking the stairs would give you more time to think through any actions you were about to take. I always thought it was good advice and over the years I've learned other ways to give myself time to pause and think before I speak—like pausing to sip coffee or taking a bite of a sandwich.

Continued on page 17



**Geriatric
Medical**

MEDICAL SUPPLIES, EQUIPMENT, AND MORE!

- ✓ Over 30,000 Items
- ✓ On-Time, Dependable Delivery
- ✓ Honest & Transparent Partnership
- ✓ Education & Training
- ✓ A Partner that Goes the Extra Mile

Continued on page ?

🔍 www.gerimed.com | ☎ 781.305.3144

DELIVERING DEPENDABILITY SINCE 1945

TRUST

"PHARMERICA'S TRANSITIONAL CARE PROGRAMS ARE A SOLID SOLUTION TO REDUCING HOSPITAL READMISSIONS."

– Shannon Lager, vice president and
chief operating officer, Medicalodges



Clients **trust** PharMerica to bring them innovative solutions that meet their evolving market challenges.

- An Antibiotic Stewardship Program to avoid F-Tags and enhance STAR ratings.
- Proactive transition of care programs that coordinate care and reduce hospital readmissions.
- Competitive and cost-effective pharmacy, clinical and cost containment services.

Let us show you why our innovative programs and services make PharMerica the right choice for your **TRUSTED** pharmacy services partner.

Call or click and let's get started.

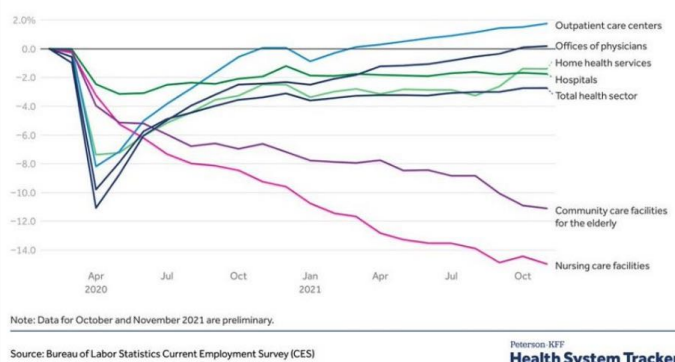
Download the entire
Shannon Lager interview at
PharMerica.com/Lager.

PharMerica
Value. Trust. Performance.

PharMerica.com
800.564.1640

The Marketing Guru: Responding to the staffing crisis

Cumulative % change in health sector employment by setting, since February 2020, seasonally adjusted



Continued from page 4

job market requires a holistic approach to “compensation”

For example, research conducted by Stackpole & Associates in 2021 shows that one of the benefits of working in long-term care is schedule flexibility. Many of the individuals working in long-term care are women, particularly women of color who are also mothers or grandmothers. They often work two jobs. Fitting their schedules together requires flexibility.

Many frontline, long-term care employees are asset limited, income constrained, and employed (A.L.I.C.E.) and have needs that other workers may not, but that can be filled by thoughtful understanding and responses to unique needs. A fresh, holistic approach toward compensation for frontline workforce is called for, as the old model no longer works in the current market.

Incentives: Double edge sword

Among the tools being used are recruitment incentives in the form of cash bonuses. Incentive bonuses for nurses and other allied health professionals are at extraordinarily high levels. The logic for these incentives is that the costs of vacancies, e.g., agencies, over time, etc. pale in comparison to a one-time payment of \$5,000, \$10,000, or even \$20,000 or more. This job market principle needs to be remembered:

“Bonuses create jumpers, and jumpers jump”! Cash bonuses are a double-edged sword.

In a declining source of supply, such as frontline workforce in long-term care, there are four recommended strategies; Protect what you have; be more efficient; differentiate services; and innovate.

Protect & fortify

When you cannot compete on payrate, do not have a competitive benefits package, and the jobs are messy and grueling, the focus should be on keeping the current staff. This approach requires stemming the exit of frontline workers. Research shows that one of the

most important reasons people quit is poor relationships. Meeting this need requires leadership and management fostering and developing relationships among the teams who care for the patients being served. Surveys conducted by Stackpole & Associates and others have shown that when employees report that, “I have a best friend at work” they stay.

Another dimension of employee retention is effectively communicating with, and especially listening to existing employees. For example, if leadership is participating in negotiations with Medicaid to improve pay and benefits for nursing assistants, tell staff what you are doing and share how hard you’re working for your staff. This can be done person-to-person in staff meetings and hallway conversations, as well as in newsletters and payroll stuffers. Even if there is no current progress in the negotiations with the state, the messages about how you’re working for them carry weight and will help protect the loyalty of your existing staff.

Increase efficiency

It is hard to think of efficiency

when you are short three CNAs for the 3-11PM shift day after day, yet this is exactly what is needed.

How much time is spent by frontline workers looking for supplies or tools that they need to do their jobs? How long does it take to record an encounter in your EHR? How much of time do your frontline workers spend waiting? Finding solutions to these and other questions can help the remaining staff accomplish more during each shift (efficiency).

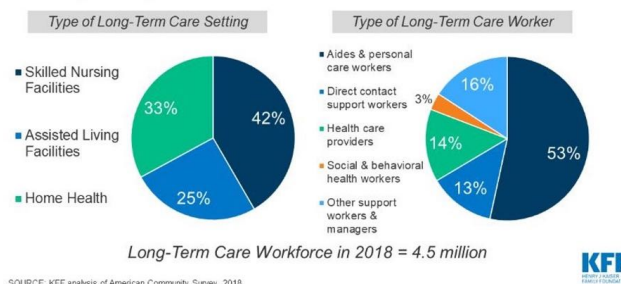
Differentiate

Why is your organization a great place to work and what makes it different from competitors? First, understand why your existing employees want to continue working for you. Ask them formally through surveys and informally in conversations and collect their reasons. Convert those insights into talking points to be shared internally and externally. Is it “flexibility” of hours or shifts? If so, emphasize these features when talking to other staff, in your recruitment ads, and with prospective employees. Make “flexibility” your focus.

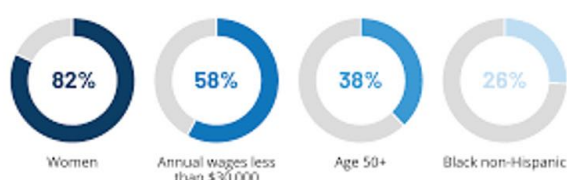
Messages and images can be funny, or serious, but make them highly visible. If a major reason for staff retention is “location” because you’re easy to reach by public transport, with amenities nearby including childcare, popular stores, and services, then promote your employment opportunities focusing on “location, location, location”. Differentiation can be based on an endless array of features. The point is that you have to distinguish yourself from competitors and clearly communicate to potential employees why they would want to work for you.

Continued on page 15

Of the Nation’s 4.5 Million Long-Term Care Workers, Two-Thirds Work in Facility Settings and Half are Aides and Personal Care Workers




The Long-Term Care Workforce is Predominantly Female and Low Wage; Nearly 4 in 10 are Age 50+ and 1 in 4 are Black



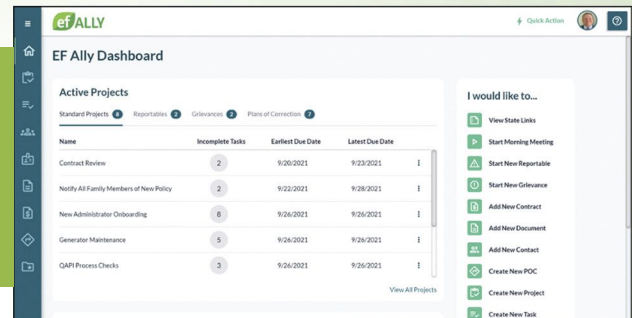


"I now cannot imagine running a SNF without EF Ally." - MA Administrator

EF Ally is a web based program that provides tools to monitor the delivery of high-quality care, customer service, Infection Control and consistent compliance.

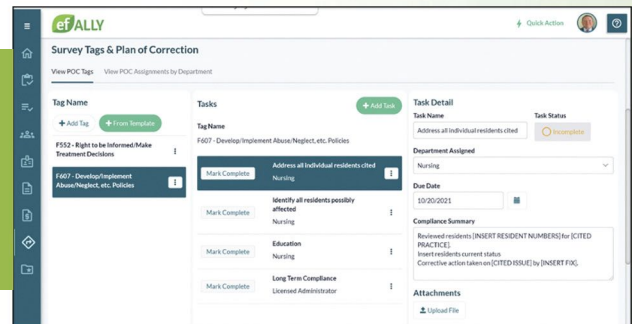


Manage Department Assignments & Workflows



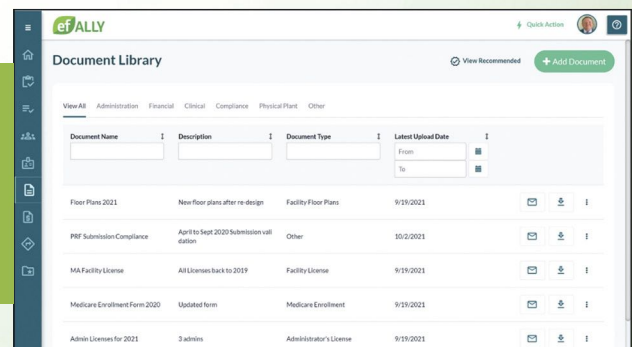


Prepare and Monitor Plans of Correction, Reportables and Grievances





Track Credentials, Contracts, Contacts & Documents



EF Ally includes pre-written POCs, the latest Infection Control best practices, and more...

Request a System Demo at [EFally.com](https://www.efally.com)

PANNONE LOPES DEVEREAUX & O'GARA LLC

c o u n s e l o r s a t l a w

PLDO attorneys are trusted leaders on the critical legal issues facing health care facilities today. From navigating the corporate and regulatory thicket of service line expansion, to minimizing the impact of third-party audits and investigations, to helping administrators solve employment matters such as those related to the FMLA, ADA and Workers' Compensation, PLDO is at the industry's leading edge. We provide mediation services to avoid costly litigation, as well as conduct contract negotiations, employee investigations, and offer training workshops on legal issues and new laws that impact organizational success.



EMPLOYMENT • HEALTH CARE • ADMINISTRATIVE • CONTRACT NEGOTIATIONS
MEDIATION • ARBITRATION • TRAINING WORKSHOPS

Contact Joel Goloskie, PLDO Partner
401-824-5130 jgoloskie@pldolaw.com

Rhode Island | Massachusetts | Florida

GREAT LEGAL TEAMS WORKING FOR YOU.

The Marketing Guru

Continued from page 13

Innovate

In the midst of what might be the worst staffing crisis, it is counterintuitive to think, "Innovate!" Yet innovation and differentiation go hand in glove. In many ways, because long-term care has been slow in technology adaptation or novel clinical protocols, small innovations will stand out you're your competitors. Your existing staff may offer insights about scheduling changes that are innovative. A particular aspect of their work may be time-consuming, inefficient and with little or no value. An "innovation" is eliminating those tasks. Beyond the staffing domain, there are administrative, record-keeping,

technology, supplies equipment – all areas ripe for innovation.

Recruitment

One domain in long-term care where differentiation and innovation are sorely needed is in recruitment. Most job opening advertisements posted by long-term care providers look and read as though they were written by overly cautious lawyers. The messages and images used for the jobs need to align with the people you are trying to recruit. Think about their age, gender, ethnicity, social, psychological and other demographic characteristics. Use language and images that would get their attention and appeal to them. You can always add the lawyerly language later; the first challenge is to engage your audience.

The second point about recruitment is to differentiate your initiatives by using channels where your likely candidates spend time, and by



p0tahoes michelle

38.8K views

2.6K Likes, 64 Comments. TikTok video from michelle (@p0tahoes): "whi... which one would you go for? #healthcare #healthcareeducation #nursingeducation #cna #cnasoftiktok #hwc #forupg #nursingstudent #tradeschool #emtssoftiktok..."

♫ The Spectre

using technologies – like video – which your job candidates are accustomed to seeing and engaging with. Facebook, Pinterest and even Tick-Tok are far more likely to generate inquiries than print ads buried in the back of newspapers, or even job ads hosted on employment agency websites. (Notice the TikTok screenshot; when was the last time your ads got 38,800 views?)

No silver bullets

There are no quick and easy this staffing crisis in long-term care. The image of the sector, especially nursing homes, has been damaged over the past two years because of frequent reports of illness and death due to the pandemic. Despite this, there are people who want to work with the elderly in aging services and nursing homes. Some of them are already

Love Your Job and Your Team Members Too

If you're a C.N.A. and are looking for job satisfaction, support and benefits, join our care team today!

For more information, visit:



working for you! Keeping the staff you have, becoming more efficient, differentiating yourself from other providers, and innovating, especially in your recruitment can help you get through these difficult times.

And please get in touch – we welcome the opportunity to help.

Copyright © 2021 by Stackpole & Associates, Inc.

Irving Stackpole is the President of Stackpole & Associates, Inc. a consulting firm founded in 1991. Irving can be reached at +1 617-719-9530, and at istackpole@stackpoleassociates.com.

Certified Nursing Assistant - One UMMS Staffing Pool
University of Maryland Medical System - Cheverly, MD
+1 Location 3.5★
Certified Nursing Assistant - One UMMS Staffing Pool. PRN - Day shift - Float Pool. The Certified Nursing Assistant, assists in the delivery of patient care...



MXD

MOBILE XRAY DIAGNOSTICS

Where image is everything

WE ARE BACK

Old is new again

Locally owned & operated • Reliable • Fast • Accurate • Easy
Joel Kirchick and Pat Tortorella are back in business to serve you!

RADIOLOGY • ULTRASOUND • CARDIAC • 24/7/365

Joel Kirchick, Principal • 508.208.7100 • mxdxray.com

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

Continued from page 3

beneficiaries, and the Remittance Advice (RA) issued to providers and suppliers.

- A minimum monetary threshold is not required to request a redetermination.
- A decision will be rendered within 60 days of receipt of the redetermination request. The results will be communicated via a letter, Medicare Summary Notice (MSN) or a Remittance Advice (RA).

Note: Expedited Medicare Part A Redetermination (Notice of Discharge or Service Termination)

For the First Level of Appeal (expedited), the MAC is not involved in deciding the results of the redetermination. A Qualified Independent Contractor (QIC) is involved in deciding the results of the redetermination. The appellant must file the request for redetermination with the contractor by noon the next calendar day from the Notice of Discharge or Service Termination.

Response:

- A decision will be rendered within 72 Hours of receipt of the redetermination request.

Reconsideration (Second Level of Appeal) Form CMS-20023

If the appellant is dissatisfied with the results of the redetermination, the appellant may enter the Second Level of Appeal and request a reconsideration to be conducted by a Qualified Independent Contractor (QIC).

The appellant must file a written reconsideration request within 180 days of receipt of the redetermination.

The Qualified Independent Contractor (QIC) reconsideration process allows for an independent review of an initial determination, which may include review of medical necessity issues by a panel of health care professionals.

In the request for reconsideration, the appellant should clearly explain the reason for disputing the redetermination decision. A copy of the Remittance Advice (RA) or Medicare Redetermination Notices (MRN), and any other useful documentation should be sent with the reconsideration request. Any evidence noted in the redetermination and all evidence relevant to the appeal must be submitted prior to the issuance of the reconsideration decision.

Evidence not submitted at the reconsideration level may be excluded from consideration

at subsequent levels of appeal unless the appellant demonstrates good cause for submitting the evidence late.

A request for a reconsideration may be made on the Form CMS-20023.

Response:

- A minimum monetary threshold is not required to request a reconsideration.
- A decision will be rendered within 60 days of receipt of the request for reconsideration.
- Documentation that is submitted after the reconsideration request has been filed may result in an extension of the decision-making timeframe for the Qualified Independent Contractor (QIC).
- If the Qualified Independent Contractor (QIC) cannot complete its decision in the applicable timeframe, it will inform the appellant of their right to escalate the case to an Administrative Law Judge Hearing (ALJ).
- The decision will contain information regarding further appeal rights.

Continued on next page

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

Continued from previous page

Administrative Law Judge Hearing (Third Level of Appeal) Form OMHA-104

If the minimum monetary threshold is met and remains in controversy following a Qualified Independent Contractor's (QIC's) decision, a party to the reconsideration may request an Administrative Law Judge Hearing (ALJ) hearing within 60 days of receipt of the reconsideration decision. The reconsideration decision letter provides details regarding the procedures for requesting an Administrative Law Judge Hearing (ALJ) hearing.

The request for an Administrative Law Judge Hearing (ALJ) may be filed on Form OMHA-104 which is called "Waiver of Right to an Administrative Law Judge (ALJ) Hearing" form.

Appellants must also send a copy of the Administrative Law Judge Hearing (ALJ) hearing request to all other parties to the QIC reconsideration.

Administrative Law Judge Hearing (ALJ) hearings are generally held by video teleconference (VTC) or by telephone.

- If the appellant does not want a VTC or telephone hearing, the appellant may ask for an in-person hearing.
- An appellant must demonstrate good cause for requesting an in-person hearing.
- The ALJ will determine whether an in-person hearing is warranted on a case-by-case basis.
- Appellants may also ask the Administrative Law Judge Hearing (ALJ) to decide without a hearing (on-the-record).

Hearing preparation procedures are set by the ALJU. CMS or its contractors may become a party to, or participate in, an Administrative Law Judge Hearing (ALJ) hearing after providing notice to the ALJ and the parties to the hearing.

Response:

- A minimum monetary threshold is required to request an Administrative Law Judge Hearing (ALJ). For calendar year 2022, the amount in controversy is \$180.00.
- The Administrative Law Judge Hearing (ALJ) will generally issue a decision within 90 days of receipt of the hearing request.
- This timeframe may be extended for a variety of reasons including but not limited to:
- The case being escalated from the reconsideration level,

- The submission of additional evidence not included with the hearing request,
- The request for an in-person hearing,
- The appellant's failure to send notice of the hearing request to other parties, and
- The initiation of discovery if CMS is a party.
- If the Administrative Law Judge Hearing (ALJ) does not issue a decision within the applicable timeframe, the appellant may ask the Administrative Law Judge Hearing (ALJ) to escalate the case to the Appeals Council level.
- The monetary threshold to request an Administrative Law Judge Hearing (ALJ) hearing is increased annually by the percentage increase in the medical care component of the consumer price index for all urban consumers.

Appeals Council Review (Fourth Level of Appeal) Form DAB 101

If a party to the Administrative Law Judge Hearing (ALJ) hearing is dissatisfied with the ALJ's decision, the party may request a review by the Appeals Council. The request for Appeals Council review must be submitted in writing within 60 days of receipt of the ALJ's decision and must specify the issues and findings that are being contested.

The request for an Appeals Council Review may be filed on Form DAB 101.

Response:

- A minimum monetary threshold is not required to request an Appeals Council Review.
- Appeals Council will issue a decision within 90 days of receipt of a request for review.
- That timeframe may be extended for various reasons, including but not limited to, the case being escalated from an ALJ hearing.
- If the Appeals Council does not issue a decision within the applicable timeframe, the appellant may ask the Appeals Council to escalate the case to the Judicial Review level.

Judicial Review in U.S. District Court (Fifth Level of Appeal) Form 1696

If the provider is dissatisfied with the Appeals Council's decision, a party to the decision may request judicial review in federal district court. The appellant must file the request for review within 60 days of receipt of the Appeals Council's decision and must specify the issues and findings that are being contested. The Appeals Council's decision will contain information about the procedures for requesting judicial review.

Response:

- A minimum monetary threshold is required to request a reconsideration. For 2022, the minimum dollar amount is \$1,760. Appellant may be able to combine claims to meet this dollar amount.
- The Judicial Review will issue a decision within 90 days of receipt of a request for review.
- The monetary threshold to request an Judicial Review in U.S. District Court is increased annually by the percentage increase in the medical care component of the consumer price index for all urban consumers.

In closing, HHI hopes this article helps clarify any confusion on the Medicare Medical Record Reviews and Appeals Process.

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 contributor to the New England Administrator. Contact Kris : 800-530-4413. harmony-healthcare.com.

Talking dirty

Continued from page 11

"Never mind," Kim said getting up. "I'll take care of it. She can either suck it up or she can move to another unit herself. I'm not dealing with this." Her phone buzzed again. She looked at it, shook her head and walked out of my office.

I swallowed the last bite of my sandwich and yelled, "Good talk," but I don't think she heard me.

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

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

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

New Englanders of note in ACHCA

Officers

Chair: Theresa Sanderson, CNHA, FACHCA , Connecticut
 Chair-Elect: Matthew Lessard, CNHA, FACHA, Maine
 Director-at-Large: Elizabeth Schmeizl, FACHA, Connecticut
 District 1 Director: Susan LaNinfa, FACHCA, CALA, CNHA, Rhode Island

Award winners

Richard Brown, FACHA, CNHA, Distinguished Service, Connecticut
 Philip Jean CNHA, FACHA, Mentor, Maine
 Ashley Soyka, New Administrator, Connecticut


Also, 13 New England administrators were nominated for the Eli Pick Facility Leadership Award.

Scenes from the 2022 Convocation (More on the next page)





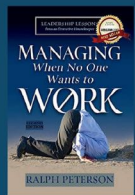

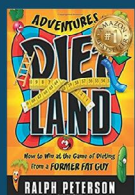
NURSING HOME OCCUPANCY BY STATE	
State	Occupancy
CT	80%
ME	78%
MA	80%
NH	80%
RI	79%
VT	78%

Week ending 3/27/22. Information provided by CliftonLarsenAllen LLP,



BOOK STORE



WHAT'S ON YOUR BOOK SHELF?

www.RalphPetersonBooks.com




SAVE THE DATE

SEPTEMBER 21 ~ 23, 2022



FALL REGIONAL IN PERSON CONFERENCE

~ PORTLAND REGENCY HOTEL ~

We will be meeting in person in Portland. Conference ,registration and hotel information coming soon!

Event Coordinator: Lexy Gonelli ~ agonelli@oriohealthcare.com

ACHCA Convocation 2022

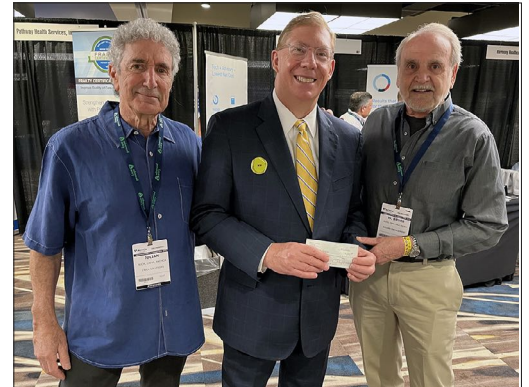
Nearly 300 ACHA members and guests gathered at the Riverside Hilton Hotel in New Orleans in March to celebrate the return of “normalcy” with the first Convocation in two years.

What better place to enjoy the recovery from covid than “The Big Easy,” with its music, fine dining, and glorious scenery?

In addition to numerous educational programs, recognition of individual achievements, vendor displays, and tours of the city, a highlight was the fund raiser, which featured a visit to the workshop where the incredible Mardi Gras parade floats are created.

New England was well-represented, with delegations from five of the six states. Notably, the Connecticut, Rhode Island, and Massachusetts Chapters provided financial support, as did The New England Alliance and The New England Administrator.

If you missed it, plan to participate next year, when the 2023 Convocation will be held at Baltimore’s Inner Harbor on April 24 to 27 (perhaps at the same time the Red Sox will be playing at nearby Oriole Park).



New England Administrator editor Bruce Glass, on the right, along with advertising manager Julian Rich presents a check on behalf of District One to ACHCA CEO Robert Lane at the Convocation in New Orleans



New England Administrator

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

Susan LaNifa, FACHCA, CHNA, CALA, District Director
slanifa@yahoo.com

W. Bruce Glass, FACHCA, Editor
bruceglass@rocketmail.com

Richard E. Gamache, FACHCA Assistant Editor
rgamache1@icloud.com

Julian Rich, FACHCA, Advertising Manager
jrich44673@aol.com

Lori Pomelow, Treasurer
lpomelow@ncaltc.com

Designed and produced by The ART of Communications
Arthur Levine
arthur@TheARTofCom.com • 978-927-5343