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Are nursing homes fading away?

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Kris B Harmony™

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Kris, a nationally recognized keynote speaker, boasts over 32 years in the healthcare industry, specializing in compliance, operations, reimbursement,regulations, and survey within the acute and post-acute health care sectors.

A Tufts University alumna with an Occupational Therapist degree, Kris further honed her expertise with a Master's in Business Administration from Salem State University and a Nursing Home Administrator's License. Kris is the proud founder of Harmony Healthcare International, Inc. (HHI), which she led for 23 years. Now, Kris is at the helm of KrisBHarmony, LLC, continuing her impactful journey. As a mother of four, Kris champions a balance of work and well-being and committed to clean living, a healthy lifestyle, and supplements this by practicing yoga.

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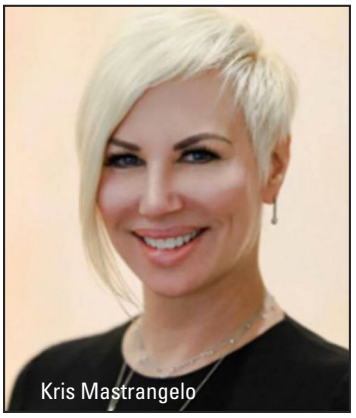
Top 11 MDS changes in LTC for FY 2024

by Kris Mastrangelo, OTR/L, MBA, LNHA

Change is the only constant, and in the dynamic landscape of the long term care industry, adaptation is key to providing quality care. As the healthcare industry steps into FY 2024, significant updates to the Minimum Data Set (MDS) are poised to make waves in how providers assess, document, and enhance the wellbeing of residents.

Major changes to the MDS v1.18.11 for FY 2024 impact patient care, documentation, form changes, and payment. Not to mention, there have been multiple and ongoing changes to all the item sets with the sixth version of the MDS item sets released October 20, 2023, i.e., 20 days after the formal implementation. The changes affect many roles beyond the MDS Coordinator and multiple factors that require consideration by the entire organization.

This article delves into the top 11 changes of the MDS for FY 2024, shedding light on what this means to skilled nursing facilities, job roles, and necessary operational refinements.


Kris Mastrangelo

1. MDS item sets increased

Given the addition of 59.5 new items rendering the most intense changes to the MDS in over 10 years, data collection and MDS completion may require additional labor hours. Hence, providers need to assess hours, systems, and reallocation of resources. While simultaneously providing ongoing education to the MDS coordinators and interdisciplinary team members.

2. Resident's voice

The MDS changes for FY 2024 are designed to create a more inclusive and resident-focused care environment. By actively involving residents in the assessment process, incorporating their perspectives, and promoting personalized care plans, these changes empower residents to have a stronger voice in shaping the care they receive in the LTC setting.

- Expanded resident interviews and participation: The revised MDS guidelines place a greater emphasis on resident interviews and engagement. By including residents more actively in the assessment process, the updates aim to capture their unique preferences, goals, and concerns directly from the source. This shift ensures that the care plans are not only clinically sound but also aligned with the individual needs and desires of each resident.
- Inclusion of resident-reported outcomes: FY 2024 MDS changes incorporate a broader range of resident-reported outcomes. This means that residents have a more prominent role in expressing their experiences and perceptions of their own health and well-being. Including their perspectives in the assessment process not only enhances the accuracy of the data but also fosters a more patient-centered approach to care.
- Focus on goal setting and personalized care plans: The MDS updates encourage a more detailed approach to goal setting based on resident input. By tailoring care plans to align with residents' individual goals and aspirations, the changes empower residents to actively participate in decisions about their care journey. This personalized approach promotes a sense of agency and autonomy among residents, reinforcing the concept of resident-directed care.
- Enhanced communication and collaboration: The revised MDS guidelines encourage improved communication between healthcare providers and residents. This includes fostering regular discussions about care preferences, treatment options, and potential changes in health status. By strengthening the communication loop, residents are better informed and have more opportunities to voice their opinions, contributing to a collaborative and transparent care environment.
- Incorporation of quality-of-life indicators: FY 2024 MDS changes introduce new quality of life indicators, reflecting a holistic

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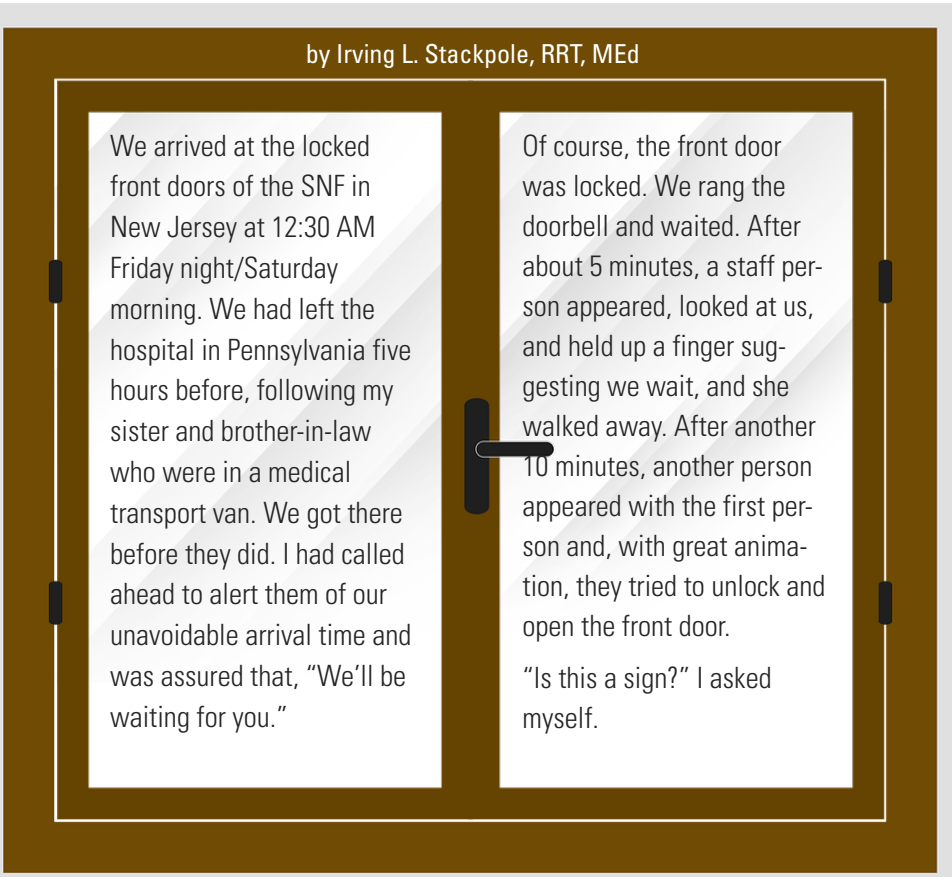
THE MARKETING GURU: My family's SNF experience

by Irving L. Stackpole, RRT, MEd



After decades in the long-term care sector as an operations and marketing executive and consultant, I have accumulated some self-confidence about data, issues, and topics related to my domains of experience. Nothing prepared me for the experience of being a consumer.

There wasn't any data I could find about the percentage of SNF admissions after hours or on weekends. However, I was able to find data from the NHS that shows that the "hazard ratio" for patients admitted during periods of lower staffing is significantly greater. Amen to that.


Irving L. Stackpole

The rest of our 26-day experience as loving, engaged, and caring family members for two of the best human beings that ever walked the earth was even more enlightening. My wife's sister and her husband died in that SNF within 10 days of each other.

Most of our experiences were bad (The New Jersey Ombudsman's office is in my phone history), some of them were dangerously bad (NJ Board of Nursing and NJ DPH are also in my phone history), and a few slices were wonderful. My purpose here isn't to excoriate that SNF, the bad actors, or the Hospice, but to share with you one (very experienced) consumer's point of view and to make some actionable recommendations.

After about 10 minutes (that seemed like 20), the two staff members figured out the problem and unlocked the doors and my sister-in-law, pushed by one transport driver, and my brother-in-law, pushed by the other, along with my wife and I entered the facility. We were led to the "short term" wing. There was a large central room, off which two corridors extended. The tables in this center room were pushed aside and the linoleum floor was piled with trash and litter. An aide sat at one of the tables eating as though half asleep; she didn't look up as the six of us trundled by.

Broken windows

There is controversial theory about perceived safety and crime, which suggests that the more derelict the neighborhood, the less safe the residents feel, and the more crime is committed there. The so-called "broken windows" theory has been widely challenged, but there's

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Going, going, ... Are nursing homes going away?

by W. Bruce Glass, MBA, FACHCA

Nearly every day we read of another New England nursing home closing. The number has reached dramatic proportions, and is beginning to cause hospital backups–something that hasn't happened since the 1980s.

Those of us who were active then (fondly) remember 98% occupancies and long waiting lists. In Massachusetts, there were 512 nursing homes, and the thought of one closing was unthinkable. Today? There are less than 400, and the number is shrinking almost daily. The picture is equally depressing in the other New England states.

So here we are. Well, some of us.

The problems are well known: assisted living siphoning off private pays, obsolete physical plants, changes in public policy, Covid, underfunding, and a misreading of the "age wave." It is a perfect storm of woes, especially in rural areas where choices are limited. Thus far, residents and potential residents have suffered less than operators, but that will surely change as the trend continues.

The reality is that the traditional nursing home was never a good model. Designed as mini hospitals, with multiple beds, long corridors, few amenities, and often shared baths, they offered barely livable conditions for folks at the end of their lives. Attempts at upgrading were too often like lipstick on a pig; they ignored the basic problem.

Waves of reform in concepts and regulations sometimes helped, but they were too little, too late. Add to that the early scandals, and it is no surprise that no one wants to go to a nursing home.

So here we are…well, some of us.

The trick will be surviving the next four years until the 85-year-olds arrive. As the number of postwar babies reach nursing home age, the demand will begin to increase–and dramatically. Suddenly there will be investors galore, sensing unlimited profits. But will the survivors or the new players learn from previous mistakes? What will the new nursing homes look like?

Very different hopefully. Probably something like the Greenhouse or small-house models, if the government will pay the extra costs. But it will be equally important to develop campus living, where elderly of all levels can live together and stay together as they become more infirm. Not unlike today's CCRCs, but with a payment system that will not require wealth. Hardly anyone wants to leave their home as they age, but when they must, it should be their last move. Home care, day care, assisted living, skilled nursing, outpatient and inpatient rehab, dementia care, and behavioral health should all have a place; not necessarily back-to-back, but on the same campus to minimize disruption.

This will provide a fine quality of life, if, of course, staff can be found to care for these multitudes. That is an issue that faces us today. The solutions must come soon, because the demographics tell us that there will be fewer and fewer young caregivers available.

So, what is that solution? Well, you are in luck because I have that answer–or at least part of it.

In many American cities, hotels and shelters are full of refugees. What to do with them? Each state should develop CNA training centers that include ESL and life skills support as well as technical skills. The government has the resources to accomplish this while individual facilities do not. Properly organized it would be a win-win, and go far to eliminate the shortage. In addition, all states should accept the concept of medtechs to dispense medications. This removes a tedious job from nurses and provides career advancement for CNAs.

Nurses are another problem. The government needs to provide more support for nursing programs, and licensure needs to be more portable from state to state. In addition, more programs are needed to advance existing staff into LPN or RN levels.

These solutions are not nearly enough. Nurses from the Caribbean, Philippines, and the Far East would gladly work in this country, except the visa process is enormously cumbersome. With luck, one might get such a nurse in two or three years under the current system. Immigration reform may be challenging, but streamlining the admission of skilled workers should be a no-brainer and even the most rabid left- or right-wing zealot should be able to recognize the necessity.

There. Now wasn't that fun?

FROM THE DISTRICT ONE DIRECTOR

Angela Perry, PhD, LNHA, FACHCA

Culture is the environment that surrounds you at work all of the time. It is a characteristic that shapes your work relationships, processes, and happiness. It is a feeling of engagement, joy, and satisfaction that will enhance your performance. First, determine what your staff desires to feel appreciated. Do not always assume it is money that leads to satisfaction. Have brainstorming sessions or surveys with your team to help determine their appreciation language.

Prioritize or rank the feedback and build a plan to demonstrate appreciation to the team. Some forms of appreciation can be conveyed by saying thank you, assisting with tasks on the unit, appropriate communication of changes, participating in unit rounds, following up, providing resolutions to issues, and implementing suggestions from the front line staff to new processes–- to name a few. Round on the units with a purpose and get to know your team. Ask how their day is going or if there is anything they may need to alleviate any stressors. As the saying goes, "You get more with honey than vinegar!"

Staff who feel appreciated and empowered are more likely to be engaged and compliant with practices. They will understand the rationale behind decisions and alleviate the us-vs-them concept. Staff will feel a part of the team and have an understanding of the greater picture to strive towards excellence in quality of care. Have front line staff participate in QAPI or Standards of Care meetings, encourage conversations during safety committee meetings, facilitate regular department heads meetings 1:1 and as a group to realign the organizations mission with departmental goals and how they all are interconnected. Explain to the team in simple terms about regulations, relationship between care systems, best practices throughout the industry, technology insights and becoming efficient.

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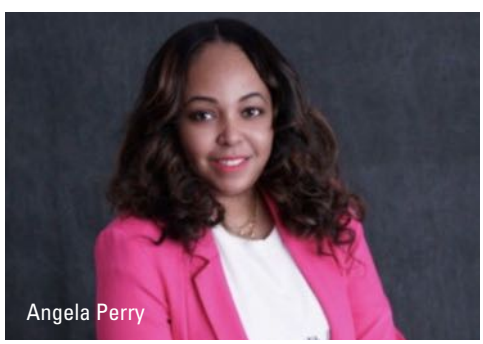

Angela Perry

Ponce de Leon, Robert Butler, and human longevity

by K.R. Kaffenberger, PhD

Ponce de Leon's Fountain of Youth Archaeological Park

We all know about Ponce de Leon and the Fountain of Youth. Presumably the 15th century conquistador searched Florida for the source of medicinal or magic waters that would imbue one with youth. It turns out that historians of the era are sure that de Leon was really seeking personal wealth and territorial acquisition. The Fountain of Youth and the search for it are both myths.

As a boy, Robert Butler was shocked and disappointed to learn of death. As an adult, Dr. Butler became a leader in social gerontology and the biology of human aging. Was the story of his youth just a myth, or did it guide his career in aging policy and studies?

Whatever the case, shortly before his death in 2010 he gave a speech, parts of which touched on the biology of aging and the benefits of caloric restriction. Butler pointed out that throughout the world many of the oldest old, including centenarians, were by culture or habit thin and had diets which minimized caloric intake.

Science had suggested that these people experienced less inflammation than those who lived normal, shorter, life spans. Butler said that in the US dieting for caloric restriction might not work well. However, he felt that we were near finding a pharmacological path to caloric restriction and its benefits.

The pharmacological path is not a myth. This year newspapers have been full of information about new drugs. In November, The Wall Street Journal reported that Mounjaro had been approved for use as a weight control medication by the FDA. Mounjaro will be sold by Eli Lilly as Sepbound and, like Ozempic and Wegovy (Novo Nordisk), is expected to change the way chronic weight management and morbid obesity are managed. Since 70% of those in the United States are obese or overweight, the Journal article predicts a huge market for these products despite their $1000 plus per month cost. Medicare does not pay for these drugs, because their use is seen as cosmetic.

In August, the Washington Post reported that a study conducted by Novo Nordisk, the maker of Wegovy, confirmed important health benefits resulting from use of such drugs. Andres Acosta of the Mayo Clinic highlighted the importance of shifting the view of the drugs from simply helping with cosmetic issues to advancing overall health. "It's a new era," Acosta said in the article, "It matters because if you lose weight, your risk of dying is reduced." And maybe either the price or Medicare may change.

All this is consistent with Robert Butler's optimistic speculation that weight reduction and caloric restriction would one day extend both the life span and the health span. But neither Butler nor other scientists have thought that caloric restriction was the only path to increased life span and health span.

One Journal article highlights the probability that high quality relationships and optimism are together and separately associated with greater health and longevity. "Among study participants, the 25% who were more optimistic had a greater likelihood of living beyond 90 years than the least optimistic 25%..."

In 2013, Poulain, Herm, and Pes published a long article, "Blue Zones: areas of exceptional longevity," which identified four physical locales where people live long lives: Sardinia, Greece, Costa Rica, and Japan. The authors dismiss things such as the mountain environment, altitude, or relative poverty as sources of longevity by using measures of association. They simply say extended life span in these places is related to lifestyle and social choices.

Many of us hope that leading a healthy life with good control over stress, diet, and exercise will help us live for a long time. In October Thomas Perls of Boston University and the New England Centenarian Study reported in the Wall Street Journal that genetics are about 25% of getting to 90, 50% of getting to 100, and about 75% of getting to 106 years of age. Healthy choices are still important; Perls estimates that only 20% of the population has the genetic background to live to 100. So, are the rest of us cursed to die earlier now and into the future?

Aviv, Kark, and Susser look at "Telomeres, Atherosclerosis, and Human Longevity" (2015) and concluded that telomeric length is a decisive factor in human longevity. The telomeres are elements of DNA that are related to replication in some cells. Short telomeres are associated with inflammation and shorter life spans. Longer telomeres are associated with longer life. The cell biology is difficult for a lay person to understand but reflects another powerful strategy for human life and health span.

Dr. Butler in several of his speeches (including versions of "Big Think" on You Tube) was also optimistic about cell biology. He expected great advances. Particularly as we chart genes and whole DNA strings the possibility of altering our genetic make up no longer seems to demand planned breeding, as with peas or mice. We may be able to use a sort of very personal medicine to alter the cells which now come to us through genetics to provide individual patients with greater longevity. Years ago, we would be stuck with the telomeres or family genetics we were born with. Maybe not in the future.

Meanwhile in February of 2023, the Mailman School of Public Health at Columbia University published a newsletter touting the outcome of research on caloric restriction and confirming in human trials that caloric restriction will extend the human life span.

So, more than 13 years after Butler's death we know he was on to at least one thing. It seems likely that there are many sources of positive adjustment to the human life span and health span. There are probably many we don't know about.

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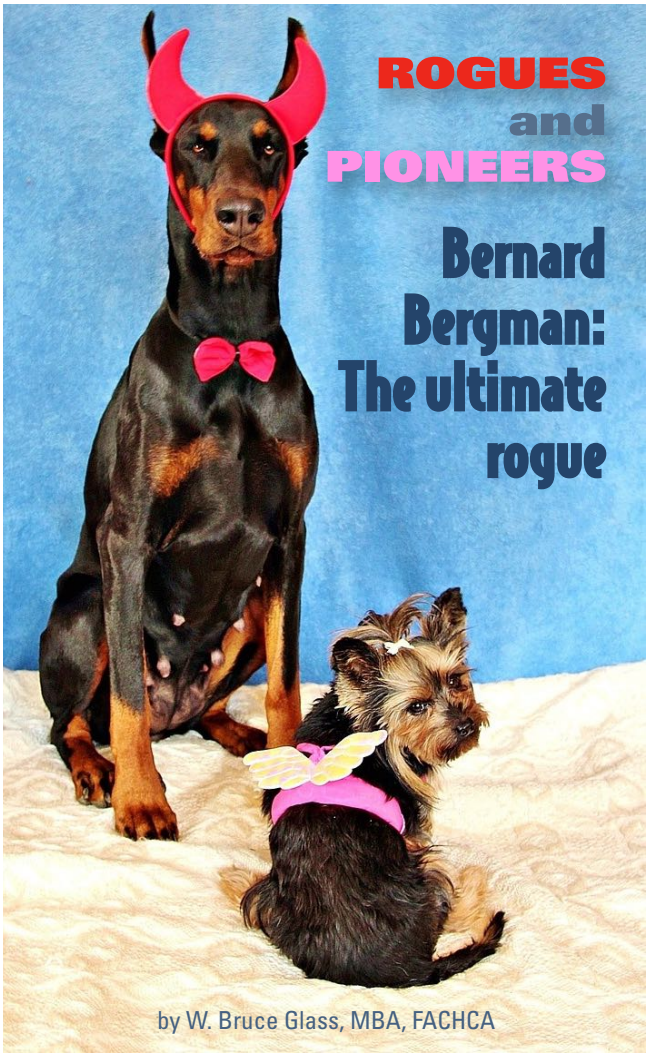

Usually, this series focuses on New Englanders who have stood out—for good or evil. Yet, when considering rogues, probably the name that has received the most attention across the U.S. is a New Yorker whose record is perhaps the most responsible for the industry's poor reputation. His scandal made the front pages of The New York Times and "Daily News," landed him on "60 Minutes," and led to investigations by New York authorities and the U.S. Senate.

Yet, Bernard Bergman was a true paradox.

Born in Hungary in 1911, he was ordained an Orthodox Rabbi in Palestine before moving to New York City as the rabbi for a Jewish nursing home. In a true Horatio Alger tale, he parlayed a $25,000 inheritance to ultimately gain ownership of several nursing homes in the city.

As his wealth increased, he established a reputation as a generous philanthropist, supporter of Israel, and confidant to numerous city and state politicians. His attorney, Leonard Rothkrug, commented, "He did more positive things for his employees than anyone could imagine." He was a prominent leader in Zionist programs, Jewish philanthropies, and local civic causes while courting favor with politicians of both parties.

In an era when regulatory oversight was minimal, the reports of poor care in his homes went unheeded for many years, especially by authorities with whom he regularly interacted. But eventually the glaring problems reached the attention of CBS in 1974, and a scathing report on {60 Minutes" focused on deplorable conditions in his facilities. Thus exposed, Governor Hugh Carey appointed a special investigator who found conditions of untreated bedsores, dehydration, malnutrition, excrement on floors, and rampant diarrhea. Further investigation also revealed massive Medicaid fraud of well over $2 million.

But his troubles did not end there. While Bergman claimed to own only two homes in NYC, he was found to be the owner or partial owner of more than 50 homes in New York, New Jersey, Florida, and the Midwest. As his hidden ownership was exposed, Bergman was also charged with failure to pay over $9 million in federal taxes, and additional charges by the U.S. Securities and Exchange Commission.


FINAL DAILY NEWS 15¢

I WAS SMEARED, BERGMAN SAYS

Nursing Home Big Denies All

Kallinger Was Called 'Time Bomb'

Ford: I'd Veto Gas Rationing

Amazingly, despite the myriad of felonies, he served only eight months in prison after pleading guilty to fraud and promising restitution for monies stolen. At his sentencing he said, "I've suffered so much. I'm not the monster I was portrayed as." With his reputation destroyed and most of his wealth gone, Bergman's remaining years were spent in Israel and his New York apartment, where he died in 1984.

The fallout from his scandals was profound. It was compounded by a book every nursing home administrator should read: "Tender Loving Greed," by Mary Adelaide Mendelson. It describes similar scandals across the country.

In New York and other states, nursing home regulations became increasingly onerous, a process that continues to this day. And the reputation of the nursing home industry still has not recovered.

Remembering Mark Finkelstein

ACHCA and our entire professional community mourn the loss of Mark Finkelstein, a long-time member of ACHCA, who passed away on November 4, 2023. Mark was an avid and passionate supporter of ACHCA, and was a member of the first class of inductees into the ACHCA Hall of Fame,

Finkelstein, a former national board member and board chair, served in the field of long-term care administration since 1972, and was one of the first ACHCA members to become certified. Mark was the recipient of the Ross Laboratories Distinguished Service Award and the ACHCA Distinguished Administrator Award. We extend our sincere condolences to his family, and celebrate the many contributions Mark made to our profession. He will be remembered as one of the passionate leaders in the long-term care profession.

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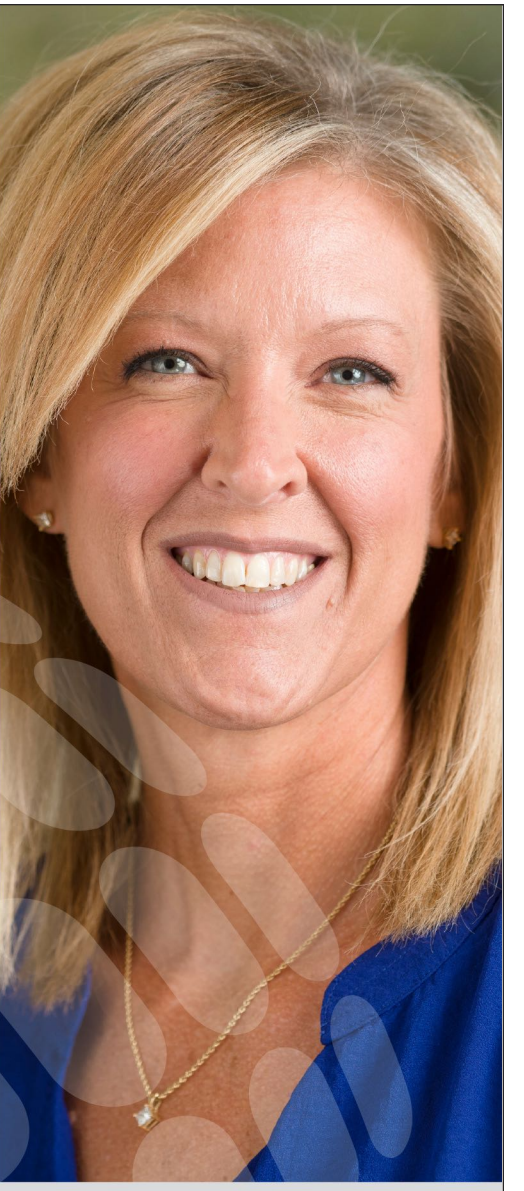

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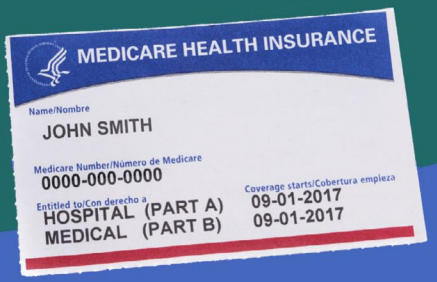

Open enrollment? Or open season?

by Nicole Fallon, LeadingAge, VP of integrated services & managed care

Medicare Advantage (MA) plans are on the hunt for Medicare beneficiaries or enrollees. Instead of hiding in a blind stalking their prey, they bombard them with marketing materials. As seniors drown in postcards, TV ads, and more promising them extra benefits for low or no cost premiums, what they don't know is how the promise of Medicare Advantage isn't always delivered.

LeadingAge published a white paper Medicare Advantage: Fulfilling the Promise in 2023 calling on policymakers to address the growing inequities between what the plans deliver and what Medicare offers. The paper outlines the challenges faced by beneficiaries and providers in this new world where more than 50% of Medicare beneficiaries have opted to receive their Medicare benefits from a MA plan or Special Needs Plan. It also offers solutions for the Centers for Medicare and Medicaid (CMS) and Congress to pursue.

MA plans are attractive, offering extra, desired benefits like vision, dental, and hearing and capping the total amount a beneficiary is required to spend on care each year. Often beneficiaries succumb to these "advantages" without realizing the potential tradeoffs or disadvantages:

- Freedom of choice of provider. MA plans have networks of providers. Some require beneficiaries to only obtain services from in-network or contracted providers. For this reason, it is important that beneficiaries confirm their preferred providers are in a plan's network before signing on the dotted line.
- Prior authorizations required before accessing certain services. No one thinks, "I might end up in the hospital and need rehabilitative care afterwards." But MA plans nearly always require post-acute care services like short-term nursing home care or home health often to be pre-approved. This is one way plans aim to control costs. Some plans are using artificial intelligence (AI) or algorithms to conduct these reviews and deny coverage for services based upon what an average person needs versus what the actual patient needs. This includes services the beneficiary would have been able to receive under traditional Medicare and are based upon a provider's in-person assessment of the person's needs and circumstances. In contrast, MA plans typically conduct a paper review having never laid eyes on the person that they say is well enough to go home. Two plans, Cigna and United Healthcare, are now being sued for their use of AI in making improper care denials and terminations.
- Inadequate payments to providers can result in limited access to certain providers. Just because a provider is in network doesn't always mean the MA enrollee will be able to be served by them. MA plans are increasingly paying providers 60% to 80% of what traditional Medicare pays them for the same service, while increasing the administrative burden on providers via prior authorizations and constant resubmissions to get paid by the plan. As a result, some providers refuse to admit an enrollee of an MA plan, or when given the option will take a traditional Medicare patient over an MA patient. This can mean longer stays in hospitals while they try to find a post-acute care provider to accept the patient. In addition, some hospitals have recently said they will no longer contract with any MA plan. For providers who accept these insufficient payments, it may spell their demise as they increasingly cannot cover their costs or hire staff because they can't pay attractive wages. Often providers don't have a choice but to sign these inadequate MA contracts because greater than 50% of Medicare beneficiaries are enrolled in an MA plan.
- MA Plans are paid more than traditional Medicare impacting future of Medicare Trust Fund. According to analysis completed by the Medicare Payment Advisory Commission (MedPAC), MA plans are paid 6% more to care for the Medicare beneficiaries than the traditional Medicare program. And yet, at the same time, they are overpaid while they limit beneficiaries' access to some services through denials and early terminations of service, and underpay providers (e.g., skilled nursing facilities and home health agencies report payments from plans are 60% to 80% of what they are paid by Medicare and sometimes even less). It also means that for every individual enrolled in an MA plan, more money is siphoned from the Medicare Trust Fund, which pays for Medicare services.

This begs the question: Is there still an advantage to Medicare Advantage?

Providers and some beneficiaries are saying no, but policymakers–CMS and Congress–have the opportunity to reform the MA program through additional regulatory and statutory changes that could return the advantage to MA plans. Reform is needed now as MA plans are responsible for delivering Medicare benefits for more than 50% of the population.

New protections should ensure beneficiary access to quality providers and provider viability by setting rate floors. They should provide greater transparency on how plans make coverage determinations and simplify the appeals process. They should enhance CMS's enforcement of plan compliance to ensure beneficiaries receive the care they need when they need it. And they should reduce administrative burden on providers by standardizing some required processes. CMS has made some progress on these issues but more is needed and enforcement is essential, as some plans have indicated they see no need to change their practices based upon the new rules. Congress also has held hearings (1, 2) looking into abuses but so far no legislation has been introduced to address these issues.

Without action, MA organizations will be allowed to continue to act with impunity and we all

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A technology report card for long term care providers

by John R. LoConte

Let's start with good news. Long-term care facilities have made significant improvements in their technology capabilities over the past several years. Gone are the days when administrators thought they had a choice whether to automate at all. Instead, organizations instinctively commit to wireless coverage, robust internet access, faster computers, med-carts on the units, and even reliable third-party support contracts with managed service providers.

On the application front, email inboxes are filling up with both critical and sometimes not-so-critical notifications, but at least there's a lot less spam to negotiate. Accounting systems are spitting out financial reports with lightning speed, medical records are routinely available in electronic format, and almost no one can even remember when or how they ever managed without computers at the center of their daily work lives.

If this sounds like you and your facility, then we in the computer business would like to congratulate you for achieving what is commonly referred to as "steady-state." While "steady-state" might seem to offer a golden opportunity to consider cost savings from either reducing IT support budgets or possibly by replacing expensive, aging hardware with less capital intensive "cloud solutions," administrators must be careful to not become too complacent.

Not only are there potential perils lurking both within and outside your technology environment, but ill-advised and uncoordinated excursions into the cloud could easily jeopardize a thoughtful and effective security posture. In any case, organizations that do not continue to explore and adopt new improvements are willingly choosing to be left behind and thus risk future irrelevancy.

Obviously, today's technology landscape is a lot more dangerous than in the past. Along with ever-present phishing scams and ransomware attack threats, there are now a variety of new social engineering challenges such as smishing, vishing, and pharming to worry about. If either you or your staff are not familiar with these terms yet, then it is highly recommended you consider introducing a formal cyber security education platform that continuously increases employee awareness.

And while you're at it, a sobering review with your favorite property and casualty insurance agent may reveal the shortcomings of your general liability policies, even with accompanying riders. This could lead you to immediately reassess your appetite for cyber liability insurance.

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The NEW ENGLAND ALLIANCE

UPCOMING EVENTS

Spring Regional Conference at Newport Harbor Hotel & Marina
May 22 to 24, 2024

Minimum staffing requirements for nursing homes: Lessons from the states

by Robert Hackey PhD, Colleen Dorrian, and Meghan Levesque School of Nursing and Health Sciences, Providence College

On September 1, 2023, the Centers for Medicare & Medicaid Services (CMS) proposed new regulations to establish minimum staffing requirements for the nation's 15,000+ nursing homes. The new policy represents a major departure from the status quo, in which staffing levels vary widely from state to state. The Biden administration should consider state experiences with minimum staffing levels in recent years to gauge the potential impact of these new requirements. The experience of several Northeastern states, namely Connecticut, Massachusetts, New York, and Rhode Island, offers a cautionary tale for federal regulators about the feasibility of the new regulations.

A recent survey by the American Health Care Association found that more than half (54%) of nursing homes were operating at a loss or had a negative total margin in 2023, while an additional 34% had a total margin between 0 to 3%.[1] In the wake of a global pandemic, nursing facilities now struggle to hire and retain workers. In Massachusetts, for example, one in four jobs in nursing homes remained vacant in early 2023.[2] Although wages for skilled nursing facility employees increased more than any other area of the health care system from February 2020 to May 2023, employment has not returned to pre- pandemic levels, and continues to lag behind other sectors.[3]

Staffing reforms in the Northeastern states

Spurred by concerns over nursing home deaths during the COVID-19 pandemic, several Northeastern states enacted staffing reforms for nursing homes in 2021. Their experiences offer important lessons for the Biden administration's efforts to develop new national staffing standards.

In Connecticut, Gov. Ned Lamont signed Public Act No. 21-185 into law in July 2021, which required nursing homes to maintain a minimum of 3.0 hours per resident day (HPRD) for direct care staff. The law did not establish separate minimums for RNs, LPNs, or CNAs.[4] While senior care advocates pressed for a higher (4.1 HPRD) standard, the state's Office of Fiscal Analysis determined this would cost the industry hundreds of millions of dollars.[5] Connecticut lawmakers revived higher nursing home staffing requirements during the 2023 legislative session. SB-1026 proposed to raise staffing requirements to 4.1 HPRD incrementally from July 1, 2024 to July 1, 2026. Failure to meet the minimum threshold would result in fines of up to $10,000 per violation.[6] The bill also specified ratios for CNAs, LPNs, and RNs – a provision staunchly opposed by the nursing home industry.[7] Connecticut faces an increasingly severe nursing shortage; while the state's nursing programs produce under 2,000 graduates each year, statewide demand for nurses exceeds 3,000 positions.[8] Nursing homes argued that "there are just too few people available to hire" to meet the new requirements.[9] Once again, legislators opted against a higher staffing mandate.

Massachusetts also established new minimum staffing ratios in April 2021. The state's new requirement set 3.64 HPRD as the minimum threshold, of which 3.58 HPRD must be provided by direct-care staff.[10] When the new regulations were introduced, many advocacy groups argued that the minimum threshold was too low. Nursing homes opposed higher minimums, however, because of the state's ongoing nursing shortage.[11] The Massachusetts Senior Care Association noted that "we are extremely concerned that a 4.1 HPPD mandate during a historic workforce crisis would have a disastrous impact on access to quality nursing home care at a time when qualified caregivers are in short supply and state and federal reimbursement already underfunds the sector."[12]

New York also established "explicit minimum hours for direct care staff" in 2021.[13] Facilities face fines of $2,000 per day for each day they fail to meet the higher minimums.[14] During the first year, nursing homes had to maintain an average of 3.5 HPRD of direct care by a certified nurse aid, a licensed nurse, or a nurse aid.[15] This includes at least 2.2 HPRD be provided by a certified nurse aid or nurse aid, and no less than 1.1 HPRD be provided by a licensed nurse.[16] By the end of 2022, more than 6,000 nursing home beds were unfilled because of staffing shortage.[17] In response, Gov. Kathy Hochul paused the implementation of New York's new staffing mandate.[18] In December 2022, the state's final regulations introduced a new waiver process for nursing homes unable to meet the new requirements.

In 2021, Rhode Island established the nation's highest nursing home staffing mandate with the passage of the Nursing Home Staffing and Quality Care Act. The new law required nursing homes to provide residents with an average of 3.58 hours of direct care per resident day (HPRD) in the first year (2022) and 3.81 HPRD beginning in 2023.[19] Penalties for not meeting the minimum staffing requirements increased with each quarter facilities were out of compliance.[20] Since Rhode Island's nursing home workforce decreased by 20% from December 2019 to June 2022, facilities asked for relief from the new requirements.[21] In 2022, Governor Dan McKee issued an executive order suspending financial penalties for noncompliant nursing homes. To date, the state Department of Health has not imposed any fines on nursing home facilities for failing to meet the new regulations, which were finalized in December, 2022.[22]

Discussion

Federal policymakers should tread warily when developing new minimum staffing mandates for nursing homes. The Biden administration's proposed regulations present facilities with a Catch-22 – to avoid financial penalties, they must hire more workers, but low Medicaid reimbursement and an ongoing shortage of direct care workers in the wake of the COVID-19 pandemic makes this difficult, if not impossible.

Governors in New York and Rhode Island suspended financial penalties for failing to meet higher staffing requirements because of workforce shortages. In Connecticut, legislators found that higher minimum staffing levels were infeasible due to workforce shortages and financial constraints. Given the current financial condition of the nursing home industry and a chronic shortage of direct care staff, a partially- or fully unfunded staffing mandate cannot succeed and will jeopardize the financial health of nursing homes around the nation.

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Life Satisfaction and Aging

by Sheldon Ornstein Ed.D, RN, LNHA

The continuity theory proposed by the researcher Havighurst, is focused on "the relationship between life's satisfaction and activity as an expression of enduring personality traits." According to the research, "Personality is considered an important factor in determining a relationship between the many roles we play in life and life-satisfaction."

Neugarten & Associates present three ideas on personality that are fundamental to the belief about the aged individual:

- With normal aging, personality remains consistent with men as well as women.
- Personality tends to influence role activity in the aged individual's life.
- Personality can also influence life satisfaction regardless of role activity.

The complexities of aging with its numerous predictable and unpredictable events that occur in the elderly individual's lifetime, have gerontologists concluding that "aging is a random process of change." They also state, "There are still numerous aspects of adult development to be explored. For example, there is development regarding love, compassion, creativity, and wisdom that can yield specific patterns about the aging process." Life satisfaction is strongly dependent on attitudes related to its connection with autonomy and independence.

As we continue to age, we are constantly confronted with the possibility of eventually having to depend on others. Undergirding this notion is the awareness that 1) there will come a time when the elderly may have to rely on others for personal or professional advice, and 2) the reverse may also occur when there will be others who will come to rely on you for medical and/or financial assistance.

Case Study: Her name was Jennie! Jennie attained the remarkable age of 100 before the winter holidays. There were numerous celebrations of her birthday by friends, family, and staff at the nursing home where I had been employed. She was delighted and surprised because little had been done on previous occasions. She always explained it away by the fact it was so near to Christmas. Aside from rheumatic aches, difficulty breathing at times although she was a non-smoker, periodic falls, and limited energy, she considered herself reasonably healthy. She woke on numerous nights with a sense of bodily urgency and then found it difficult to fall asleep again. At those times she would sip a shot of brandy that was hidden from staff. Jennie once claimed, "Getting old is like a one-horse shay–everything falls apart." Jennie had a large network of acquaintances and an attentive family.

Although she was acquainted with the anguish of grief and loss, Jennie would never allow herself to mourn indefinitely. She once stated at a monthly residents' meeting, "I haven't got much time left to be depressed."

Why have I portrayed this glimpse of Jennie? In my opinion, Jennie had already reached that singular moment in her life, with all her aches and pains that accompanied her into old age, with an attitude of no regrets. She had that unbreakable belief that there is more to be accomplished. Jennie was the proverbial optimist despite her advanced age. She left us at 103 with numerous grandchildren and close family members gathered around her bedside for one last and loving goodbye to a unique person.

Currently, there are numerous programs being introduced through education to rectify the public's distorted impressions that old age is perpetually grim with associated illnesses.

The assumption still prevails that growing old is a downhill projection. Unfortunately, there are many who still believe this. Nothing could be further from the truth.

Rehabilitation then becomes a realizable part of care for the aged. It is, in fact, the key for returning the aged individual to what has been documented as a "wellness continuum." Rehabilitation involves strengthening of weakened muscles, increased range of motion to the extremities, locomotor skills, etc.

According to the researcher Farquar, approximately 86% of the aged population have or will eventually experience various chronic conditions while 95% of these same individuals will still be able to live and thrive in their communities. Maggie Kuhn, founder of the Gray Panthers, an advocate organization for the aged states, "The image of the poor and sick old has been continuously emphasized by the mass media despite the fact that it does not reflect the real world of the aged."

In truth, the aged continue to be active and achieve self-satisfaction with their lives. In other words, they are *productive and useful.*

The practical value of the wellness concept, mentioned earlier, with all its proven implications for the aged, begins with a desire for continuous intellectual and spiritual growth and an abundance of healthy opportunities for change. Yes, even Jennie, at 103, achieved her desire for satisfaction in life and then some.

Quotable Quote

"The noblest art of man is making others happy."
-Anon.

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

Before you think I'm some sort of genius or a gifted muse, able to look deep into the future and plan a path to a promotion, I'll admit that mostly, I was bored.

It had been a long winter, the early signs of spring had just started, with warmer afternoons and later and later sunsets, and I was restless. I had been working in the same nursing home for two years at the time, and to say I was ready for something else–anything else–would have been an understatement.

That's when I got the email.

In fact, that's when we all got the email. There was a nursing home a few hundred miles away that needed help. They were reaching out to all the department heads in all their centers, looking for volunteers.

"Hmm," I thought when the notice came out. "Why not?" It had to be better than sitting here having the same arguments with the same staff day after day. I responded with a simple email: "I'll go."

A few weeks after I came back, another notice arrived seeking volunteers.

"I'll go," I wrote back quickly, without reading the entire message. I had fun the last time I volunteered and honestly, I enjoyed the challenge. The center had recently been acquired by my company, and I spent two weeks with the HR Director onboarding a couple hundred new employees. It was a great learning experience.

This time however, I should have read the email. They were looking for people to help with a few overnight projects. Cleaning projects. But I already said yes, so I went.

It wasn't that bad.

That summer, I volunteered to help on five different occasions, in five different

centers all over New England. And, again, just to be clear, I wasn't volunteering to show how good of a person I was. I wasn't even volunteering because I liked to help others. I was just bored and looking for any reason to be anywhere else.

Then we got another request. This time, however, the email said, "We are looking for volunteers to help out in xyz nursing home and then in parentheses it said, (not Ralph Peterson)."

I felt sick to my stomach. Did I read that

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The top MDS changes

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approach to resident well-being. These indicators encompass social, emotional, and cultural aspects of life, allowing residents to express their values and priorities beyond just clinical health. This comprehensive view enables care providers to tailor services that not only address medical needs but also enrich the overall quality of life for residents.

3. Triple check process

Monthly triple check meetings are particularly important with the MDS changes including those in the errata documents. The October 20, 2023, MDS Manual Errata (v2) document is 54 pages and has 21 changes applicable starting October 1, 2023.

The MDS updates and numerous software glitches have caused multiple issues with submitting accurate claims. Changes with items in MDS sections include:

- Section D: Resident Mood,
- Section K: Swallowing/Nutritional Status, and
- Section O: Special Treatments, Procedures, and Programs

These require close attention, or reimbursement opportunities may be missed.

A separate triple check meeting for Medicaid claims is recommended given the complexity of many MDS and billing changes related to using the PDPM Nursing Case Mix Group. A distinct, detailed, and comprehensive review of the Medicaid claims for states that use the additional OSA for reimbursement should also be held given the inverted scales used, the "rule of 3" versus using usual performance, and the learning curve for new definitions of multiple items.

4. Social determinants of health

Social determinants of health play a crucial role in influencing an individual's overall wellbeing, and their impact is increasingly recognized in the healthcare landscape. The MDS in the LTC industry serves as a comprehensive assessment tool, and its integration with an understanding of social determinants can significantly enhance the quality of care provided. Here's how social determinants of health relate to MDS in the LTC setting:

- Holistic assessment of residents: Social determinants, such as socioeconomic status, living conditions, and community resources, can influence an individual's health outcomes. MDS assessments, when designed to consider these social factors, provide a more holistic understanding of a resident's situation. This holistic approach helps in tailoring care plans that address not only medical needs but also social and environmental factors impacting health.
- Identification of barriers to care: MDS assessments can uncover social determinants that may act as barriers to optimal health. For instance, if residents lack access to transportation, it could impact their ability to attend medical appointments. By identifying these barriers, healthcare providers can develop targeted interventions to mitigate the effects of social determinants and improve access to necessary care.
- Customization of care plans: Social determinants influence an individual's ability to engage in their care. MDS data, when coupled with an understanding of social factors, allows for the customization of care plans that are sensitive to the unique needs and challenges residents face. This ensures that interventions are realistic and achievable within the context of the resident's social environment.
- Enhanced communication and collaboration: Integrating social determinants into MDS assessments fosters better communication and collaboration among healthcare professionals, social workers, and other members of the care team. Understanding the social context enables a more comprehensive and collaborative approach to care planning, with a focus on addressing both medical and social needs.
- Risk stratification and targeted interventions: Social determinants can contribute to health disparities and affect the risk profile of individuals. MDS assessments, when enriched with information about social determinants, enable risk stratification. Identifying residents at higher risk due to social factors allows for targeted interventions and support services that can positively impact health outcomes and prevent avoidable complications.
- Quality improvement initiatives: Analyzing MDS data in conjunction with social determinants helps identify patterns and trends in health disparities. This information can inform quality improvement initiatives aimed at addressing systemic issues related to social determinants of health within the LTC facility. This proactive approach contributes to better overall resident outcomes.

Recognizing and incorporating social determinants of health into the MDS framework in the LTC industry is crucial for providing person-centered, comprehensive care. By understanding the social context of residents, healthcare providers can develop interventions that not only address immediate health needs but also work towards creating a supportive and health-promoting environment tailored to everyone's unique circumstances.

5. Standardized patient assessment data elements

The SPADE items are in the APU Table which was revised for the QRP Data Submission Threshold. Data collected after January 1, 2024, will affect the QRP Program Year 2026 when the threshold will be 90% instead of 80%.

6. Functional status: Section G elimination

The elimination of Section G (Functional Status) from the MDS impacts an array of areas including but not limited to; the loss of functional status Information, an Impact on care planning, the source data for quality measurement and benchmarking, interdisciplinary communication, reimbursement implications, as well as the adaptation to changing standards:

While all are extremely important, it is important to note that Section G impacted five quality measures and both the quality measure and the staffing components of the Five Star Rating System. The calculations for quality measures will change after a freeze period (starting in April 2024) when four measures will be frozen with three of them remaining frozen until January 2025.

7. Data transparency

The information available to the public, referral sources, and others is increasing with reporting on Care Compare, the Provider

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MDS changes

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Data Catalog at Data.CMS.gov and elsewhere. These sites include data based on the new MDS items. For instance, the transfer of health data posted to Care Compare in October of 2025 will be based on the pertinent items that are new on MDS 3.0 v.1.18.11.

8. Medicare Part A PPS Discharges complexity

The Medicare Part A PPS Discharge Assessment (NPE) item set increased from 13 to 23 pages, a 76.9% increase. The timing of interviews that it includes such as the BIMS, PHQ 2-9 resident mood interview, and the pain assessment can be confusing, especially if there is an unplanned discharge. These items count towards the provider's SNF QRP data completion threshold.

The new requirement in the MDS RAI Manual, chapter 2, page 2-44 changed the guidance about combining a PPS discharge assessment with an OBRA discharge assessment so that when the Medicare Part A Stay ends on the same day or the day before the day of discharge from the facility these assessments must be combined. As a result, the timing of multiple interviews including the SDOH items, even with an unplanned discharge, are critical given the SNF QRP data completion threshold.

New NPE items improve discharge planning and will be useful to ensure attainment of the surveyor guidance for F-Tag 660 and F-Tag 661.

The Discharge function score for SNFs that will be included in both the SNF QRP, and the value-based purchase program has data collection starting October 1, 2023, and the performance year slated to begin October 1, 2024. Currently, this does not impact reimbursement, but MDS accuracy will make a difference when it does.

9. Resident mood – PHQ 2-9: Section D

The transition in MDS Section D from the PHQ-9 to the PHQ-2-9 to assess resident's mood (conducted during the ARD 7-day look-back period) can be a shorter interview with a skip pattern depending on how the first two questions are answered. The PHQ-2-9 and the RAI Manual change regarding when a staff interview can be conducted, may cause a decline in MDS with a depression endsplit. It does not necessarily change the quality measure and should not impact the need for comprehensive interdisciplinary care planning or looking for any significant changes in the resident's mood.

Monitoring the PHQ-2-9 scores, providing additional training on the interview process and the PHQ-2-9 assessment, and enhancing the care planning process will assist with providing quality care, survey outcomes, and reimbursement.

10. ICD-10 coding

The new updates to the ICD-10-CM code system for fiscal year 2024 include 395 new billable codes in areas such as external causes of morbidity, social determinants of health (SDOH), and osteoporosis.

Understanding the ICD-10 Code changes for FY 2024 and the updates to the ICD-10 Mapping File released September 2023 impacts coding of several sections of the MDS. For states that use PDPM for Medicaid reimbursement (in addition to Medicare Part A), the financial impact is much greater.

Documentation must support the MDS coded diagnoses following the RAI Manual guidelines. It is important that physicians understand the full implications of certain ICD-10 Codes and that staff have a streamlined query process for clarification of diagnoses as needed

11. Training and clinical leadership

Updating the facility policies and procedures to properly reflect these MDS changes must be completed and implemented expeditiously. Education with frequent trainings about the revised policies and procedures, the reasons for the changes, combined with information on the MDS changes and their importance is critical. Following up on this to gauge how the clinical team is adjusting to these significant MDS and RAI Manual changes is equally essential.

Success with the above requires aligning operations with the MDS changes and regulatory expectations plus recognizing the key factors of quality, safety, and person-centered care. Education, audits, more education, and a strong QAPI program will make a difference with the new MDS changes.

Kris Mastrangelo, OTR, MBA, NHA, is a nationally-recognized authority of Medicare issues. She is a regular contributer to the New England Administrator.
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Human longevity

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There is pretty good evidence that a healthy lifestyle helps. We expect that cell biology will lead us to a number of other choices.

But for right now, we know that pharmacological caloric restriction is made much easier by drugs such as Mounjaro and Wegovy. They give us a tool that will definitely extend the human life span. And it will help people who are alive now, as well as future generations. It is not the fountain of youth or some other myth. These tools have been tested and accepted by both scientific and commercial communities and are currently available.

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

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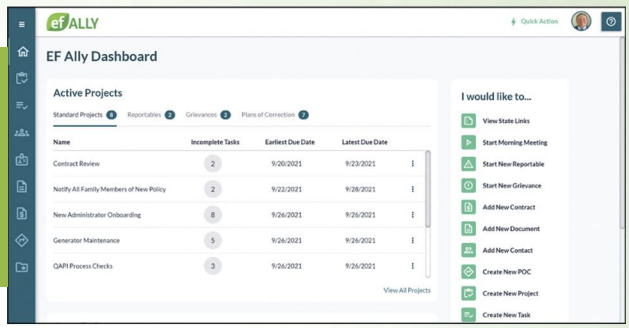

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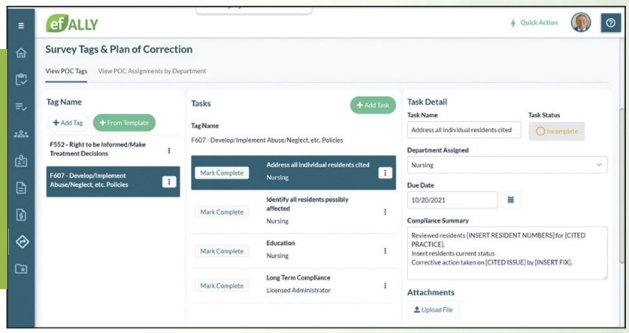

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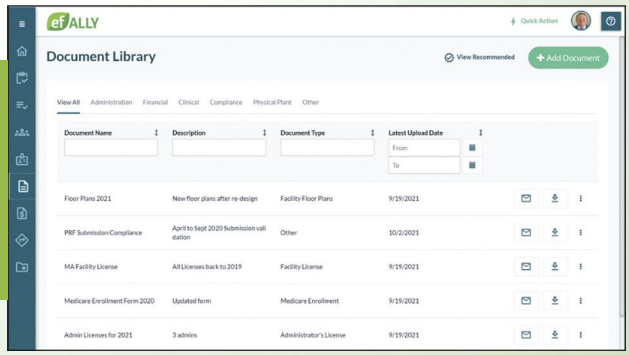

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The Marketing Guru shares his family's SNF experience

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no doubt that damaged, dirty, and decrepit interiors in nursing centers create a negative impression.

After having visited over 2,500 nursing homes in my career, I was ready for duct tape. The level of capital improvement in SNFs has been hampered by many factors, not the least of which is that nursing homes cannot (generally) qualify for further debt since they're already heavily leveraged, and they're unable to service the types of loans which other real estate-based operations (like hotels) use for refurbishment and updates.

The site of the trash, and the lack of any positive greeting was deeply dispiriting.

Recommendation

Pick up the trash! Andrea (the names have been changed), the administrator at this nursing home in NJ, should take a cue from Mike Dukakis. The last time I saw the Governor and presidential candidate in Brookline (where I lived for a while), he bent over and picked up a McDonald's cup and threw it in the trash. Andrea walked by a lot of trash while I was there.

Who's running the asylum?

The staff: "Have you asked Shirley? I think Shirley does that. Shirley knows where the humidifiers are. I'll ask Shirley when she's back from break."

The administrator: "Anything you need, just let me know."

No, Andrea. I'm going straight to Shirley.

There are a few people who really run your SNF operations, and it's not you, the administrator. Each unit has one person who knows where the bodies are buried. No one crosses Shirley. I watched Shirley "dress down" not only aggressive patients but doctors and other staff; it wasn't rude or rough, although it was very confrontational.

Recommendation

Find out who your key people are and support them any way you can. Acknowledge them and their work in ways that resonate.

Find a way to get Shirley to start picking up the trash, and I promise you, within 5 days you won't see a speck. (All of you reading this know who Shirley is and are intimidated to ask her. But if you do, and this works, please tell me.)

Plugging holes isn't delivering care

Just because the shift is covered, it's often not enough.

My interaction with an agency nurse. Jessica, my niece, called from the center one evening to say: "We don't know why, but Nurse Betty won't give Alice (my sister-in-law) the morphine.

Me: "Did she offer a reason?"

Jessica: "She doesn't want to wake her up."

Me: "Does the nurse know that she's on hospice and that IF she wakes up, it's because she hasn't had her medication?

Wrong-time, wrong-dose, wrong-medication errors are happening all over the place, and they are not being reported.

Flummoxed silence. Then I get Nurse Betty on the phone, who explains: "I really don't think it's nice to wake people up for medication. They need sleep."

Me: "While I agree about sleep, Alice is a terminal cancer patient on hospice, with breakthrough pain, and if she arouses, it will be because of pain. And are you aware that failure to administer a medication on time is a medication error for the SNF [this would be the third such error in two days], and if you refuse to follow the doctor's orders, that's a reportable offense to the licensing board?"

Nurse Betty: "It's just not what I do."

Me: "Are you an agency nurse?"

Betty: "Yes."

Tough pill to swallow: Medication errors

During the 21 days I was at my relatives' bedside, I personally witnessed 11 reportable medication errors, and I am certain that more occurred. None of the errors I witnessed were recorded or reported. None, zero, niente. My conclusion is that wrong-time, wrong-dose, wrong-medication errors are happening all over the place, and they are not being reported. You cannot manage what you are not measuring.

The computer system at the nursing home was relatively new (a reputable, respected software), and most of the nurses struggled with it (although not Shirley). The system was down for almost an entire shift one night, so no meds were passed. Really. (OK, make that 16 errors.)

My observation about medications administration in nursing homes is that accuracy will not improve until the errors are counted, and counting will only happen when nurses are no longer punished for reporting errors. That's never going to happen in this punitive, "gotcha" culture. Shit rolls downhill; when there's a med error, Andrea gets in trouble, then Barbara the DNS gets in trouble, and then she has to talk to Shirley, and we know how that's going to go.

Weekends are a nightmare

We stayed overnight a few times because of my sister-in-law's condition, and what we didn't see was care. Medications weren't administered, call lights were unanswered, and patients weren't being taken care of while aides napped. Staffing gaps and cultural issues are really apparent on the weekends.

Recommendation

Value your family members. Active, engaged, and present family members of residents know very well what's going on with their relatives, so listen to them carefully. Some staff members were incredibly responsive to our needs, our suggestions, and our observations. Others treated us like we were idiots who didn't know what we were talking about, and that they knew better. It was insulting, offensive, and just added to the stress of an already very challenging situation.

If you don't have an active volunteer corps, perhaps you should consider developing one. It might be very illuminating to attempt to recruit family members for a "citizen" corps to help. If you hit obstacles, ask yourself and your team, "Why?"

My bet is that Shirley knows the answer.

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Medicare Advantage

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will pay. These plan practices threaten access to providers, threaten the Medicare Trust Fund, and risk beneficiaries' health by improper care denials. So, we renew our call to policymakers to address these practices by pursuing MA reforms that protect beneficiaries, ensure equitable access to care, and provide a financially viable path for providers to continue delivering needed services. Make all MA plans fulfill their promise and once again deliver an advantage.

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Maybe it's time to conduct a technology assesment

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However, the most important aspect of a cyber insurance review is not necessarily the dollar amount of coverage or even the level of reduced exposure. Instead, regardless of whether you purchase cyber liability policy, you will find that almost all carriers require certain fundamental security measures. These include multi-factor authentication (MFA), end-point detection and response (EDR), and a robust backup, recovery, and business continuity plan which, if not in place, could disqualify you from even obtaining coverage.

Nevertheless, while there may be plenty to be worried about with technology, attempting to scare people into achieving future success is not necessarily an effective business model. Instead, an organization that is committed to moving beyond "steady-state" needs to balance legitimate threats versus the exciting opportunities that are readily available.

One obvious area for improvement is the vendor management/check processing function. This is an extremely labor-intensive process that starts with ordering supplies and services, mail opening, data entry of invoice details, departmental approvals and/or matching of purchase orders, selection of checks for payment, printing, stuffing and mailing checks, invoice filing, reconciliation of bank statements that could contain hundreds of checks per month, and finally, storing the multitudes of paper for safekeeping. Along the way there is also the possibility of paper check fraud schemes, printer malfunctions, or plain user input error.

Although many organizations have added positive-pay and ACH payments into the mix, today there are software companies that have completely revolutionized the entire process. These providers utilize optical character recognition (OCR) from scanned or emailed invoices to capture pertinent information such as vendor name, invoice number, and invoice amount. Their systems contain automated routing for approvals and full integration with general ledger and accounts payable software modules.

So rather than continue to devote limited internal accounting staff resources to tedious vendor payment tasks, the AP automation providers perform these functions as soon as the authorized signer selects the checks for payment. The time saved from automating these tasks can be better channeled into producing even more meaningful reporting while also enhancing services to both residents and their families.

Similar opportunities for improvement in other key areas such as communications and collaboration are also available, but the primary takeaway should be that future IT attention should not be about on-premise servers, hosted solutions, or cloud-based technologies. Rather, conversations with management need to focus on the functions, policies, and procedures that are critical to the overall future success and growth of the organization. Once key initiatives are identified and prioritized, selection of appropriate supporting technology will become obvious.

In conclusion, many may be of the if-it-ain't-broke-don't-fix-it mindset and conclude that steady-state is just fine for them. However, it takes visionary management decision making in conjunction with astute technology resources to realize that things might actually be more broken then many may care to admit. By doing so, however, administrators and their facilities are more likely to fully realize the benefits from their future technology commitments.

As a former owner of a regional Managed Services Provider and a licensed CPA and insurance producer in the State of Florida, John LoConte, is Principal of Vista Strategic Advisors (www.vistastrategicadvisors.com), LLC, a virtual CIO and CFO consulting firm specializing in assisting human service, long-term care and professional consulting organizations develop, implement and maintain their technology, financial and social media presence strategies. John can be reached at 617-799-3304.

The road to gold: Say yes!

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right. I closed my eyes tightly, trying to shake it off. Thinking I read it wrong. I read it again: not Ralph Peterson. What the…?

I spent the next two days wondering what I did wrong. Two days of wondering why my boss's boss (the regional DO) would mention me in the email. Two days of wondering if I should be working on my resume and looking for a new job.

Then he called me and told me someone had put in their notice and he was looking to promote someone from within. He asked if I would be interested.

"Yes," I said. "But I thought you were mad at me, or that I did something wrong. Because of the email." He laughed.

"Oh, I should have explained. You are the only one who ever volunteers and I wanted someone else to volunteer," he said. "It''s not fair that you are always the only one." It was my turn to laugh.

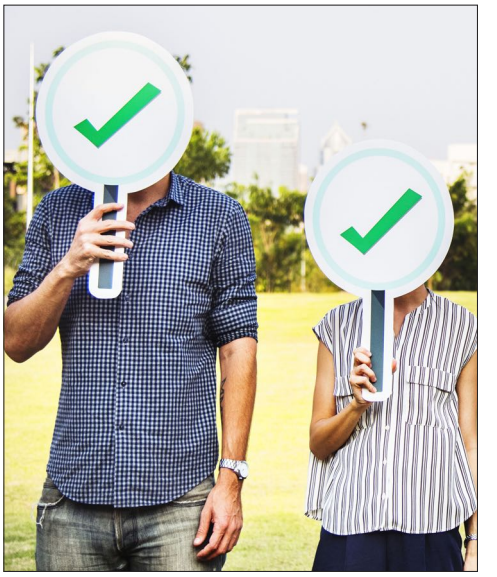
"Oh," I said. "I don't mind."

"I know," he said. "That's why I thought of you when this position opened up."

Now don't get me wrong. There have been plenty of times when I've said yes and volunteered that didn't land me a promotion. At the same time, there have been plenty of times throughout my career that I've said no. The difference is, I've never been promoted for saying no.

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

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



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Lead with a purpose!

Diversity is represented in many ways that may include race, ethnicity, disability, religion, skill set, or interests. It is imperative to understand the melting pot of your organization's environment and what each member brings to the table. Opportunities to improve culture in the form of diversity is to present your "position statement" as the leader.

Form a committee where staff can share ideas about opportunities to enhance the visibility of diversity for what you want to accomplish holistically. Consider scheduling cultural events periodically to highlight the theme with various sub-topics on each occasion. Incorporate surveys, trivia, team building activities, poems, food, music, targeted workshop, and other engaging elements based on your desired goals to name a few.

Overall, culture is multilayered! Reflect on recent challenges and how to improve morale, quality of care goals, patient satisfaction, and relationships with families or other stakeholders. Culture is an interconnected web that needs each strain to be successful!

EDITORIAL

Should Assisted Living Administrators be licensed?

by W. Bruce Glass, MBA, FACHCA

Nursing home administrators have been licensed since the 1960s, with a requirement for ongoing CEs. Interestingly, it is the only level of healthcare management that universally requires such licensure–not hospital executives, not home care, and, only occasionally, assisted living.

Here in New England, only Rhode Island and Maine require licensure. New Hampshire and Vermont list required standards, but not actual licensure. Connecticut and Massachusetts: not so much. Unlike nursing homes, assisted living regulations are the sole province of each state, so conditions and standards vary widely.

Assisted living administrators are responsible for the well-being of frail elders under their care as well as the management of multi-million dollar operations. Is it not time to reassure the public and authorities of their professionalism?

I believe all states should extend this requirement, especially in New England where we pride ourselves as healthcare leaders at the forefront of quality care.

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