New England
ADMINISTRATOR

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2021

"Kindness is the language which the deaf can hear and the blind can see."
-Mark Twain

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ACHCA
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Health Care Administrators

Industry in crisis

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Quality measures–Fabulous 15 and Lucky 13

by Kris Mastrangelo, OTR/L, MBA, LNHA

The industry is overwhelmed with information on COVID, PDPM, Survey, Vaccination Mandates, Infection Control, and Staffing to name a few. This article is intended to help operators and clinicians gain a more organized understanding between the differences in the many quality measures from multiple sources, specifically the Five-Star Quality Rating Quality Measure Domain and the SNF Quality Reporting Program (QRP).

First and foremost, a quick review on the overall five-star quality rating system. This system is comprised of three components including:

- Health inspection domain
- Staffing domain
- Quality measure domain

Five-Star Quality Rating Quality Measure Domain

	FABULOUS 15	SOURCE
1	% Falls with Major Injury	Long stay
2	Pressure sores	Long stay
3	UTI	Long stay
4	Catheter use	Long stay
5	ADL decline	Long stay
6	Antipsychotic medication use	Long stay
7	Locomotion on the unit	Long stay
8	Number of hospitalizations	Long stay; claims based
9	Number of ER visits	Long stay; claims based
10	Improvement in function	Short stay
11	Newly received antipsychotic medications	Short stay
12	Pressure ulcers new or worsened	Short stay
13	Successful return to home/community	Short stay; claims based
14	Rehospitalization after nursing home admission	Short stay; claims based
15	ED visit	Short stay

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HHI refers to these quality measures as the "Fabulous Fifteen" because the Five-Star begins with an "F" and there are 15 quality measures in the Five-Star Quality Measure domain.

HHI refers to its QRP quality measures as the "Lucky 13" because there are 13 quality measures in the program. However, this will be changing in approximately 2 years.

The 13 existing SNF QRP quality measures plus two new ones (transfer of health information to provider post-acute care (PAC) plus transfer of health information to partient PAC) increases the total SNF QRP quality measures from 13 to 15. Ultimately, the SNF QRP will have the same number of quality measures as the Five-Star Quality Measure Domain.

Also, please note there are two additional measures from the FY2022 SNF PPS Final Rule:

- #11 SNF QRP COVID-19 Vaccination Coverage Among HCP
- #15 SNF Healthcare-Associated Infections (HAI) requiring Hospitalization

The data for the above two newer SNF QRP quality measures will be reported much ear-

Continued on page 16

Kris Mastrangelo

Long-term care has been GRINCH'D

by Irving L. Stackpole, RRT, MEd

WHAT DOES THIS SEASON HAVE IN COMMON WITH LONG-TERM CARE? JUST AS SUPPLY CHAIN DISRUPTIONS WILL LEAVE SANTA CLAUS' AMAZON-LABELED SACK EMPTY, THE HISTORICALLY FRAUGHT, BUT USUALLY RELIABLE SUPPLY CHAIN OF FRONTLINE CAREGIVERS HAS BEEN GRINCH'D.

For decades, the underfunded long-term care sector has sputtered along paying barely above minimum wage for a workforce which is (or rather, has been) predominantly women, women of color, and very often first- or second-generation immigrants. This is hardly controversial; these are the facts. These jobs have been accepted primarily because of accessibility (low-income individuals can economically get to congregate care facilities), flexibility (often better-paying, off-hour shifts can be coordinated with daycare and other jobs), and ESL tolerance.

Irving L. Stackpole

The pandemic has plummeted occupancy in congregate long-term care and exposed the rotten economic underpinnings of the sector, in addition to contracting the need for low-wage workforce. The recovery in most marketplace areas is resulting in rapid wage growth among service-related and light industrial sectors. We have all seen the ubiquitous "Help Wanted" signs. Therefore, the same asset-limited, income-constrained individual who had been a reliable aid or food service worker in the nursing home, now has an opportunity to make $5, $6, or even $7 dollars more per hour. Not a tough choice.

McDonald's, Home Depot, and Jiffy Lube have the option to pass these incremental labor cost increases on to their customers ("inflation"). However, state and federal intermediaries for congregate long-term care (payment sources), on which the sector relies for 70%+ of its revenue mitigate against passing along these cost increases. Even where nursing homes or residential care homes can apply for rate increases, the delays in securing the needed increase in payments send operations perilously deeper into the red. Days cash on hand was briefly buoyed by stimulus funds, but most of these have already been disbursed, once again leaving many operations perilously close to insolvency. And even though demand is returning, some nursing homes report that they're not able to admit because of staff constraints.

The threat at this point is so existential, that any successful response must be collaborative, exigent, and at scale. The sector does not have a history of responding this way. What's more likely is that operators in specific marketplace areas will have to adopt a "last one standing" strategy. It's not pretty, but here's what it looks like:

1. Hold on to what you've got

As it becomes more difficult to recruit, it's absolutely critical to retain the staff you have. The churn in front line workers in long-term care, as we all know, would make turnstiles spin right off their hinges. The best research shows that people stay in jobs where they feel personal connections to other workers, their supervisors, or the mission/purpose of their employers. This isn't about, "being nice;" it's about creating a culture–today–where "caring" is not only what you expect your staff to do, but what they do with each other, among themselves.

2. Know why they leave

For as many departing staff as possible, make a bona fide effort to find out why they're leaving. We are entering the "great resignation" workforce economy in general, in which workers now feel emboldened to try new things, jump career paths, and retire early. No operations manager in a congregate care center can fight against these forces, but it is imperative to discriminate–at a granular level–between unpreventable and preventable turnover. (W Edwards Deming, the father of CQI, TQM, and everything else related to modern enterprise improvement, defines Quality as "…the de-

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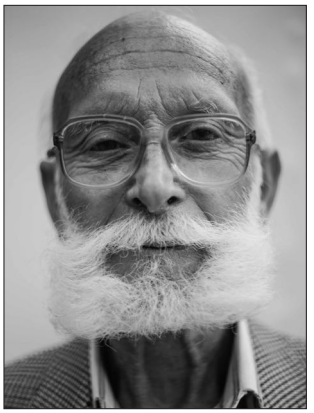
Establishing a legacy and aging

by Sheldon Ornstein Ed.D, RN, LNHA

A legacy is one's tangible and intangible assets that are transferred to another and may be treasured as a symbol of the individual who is bequeathing it. The elderly should be encouraged to identify that which they would like to leave and who they wish their recipients to be. This process has great significance and tends to prepare one to "leave" with a sense of meaning.



Legacies can provide a feeling of continuation and tangible ties to their survivors. Legacies may range from memories to material bequests that will live on in the minds of others. The researcher Erik Erikson's seventh stage of man identifies the generative function as the main concern of the adult years and the last stage, the eighth, as that of reviewing with integrity or despair what one has accomplished.

Following are suggested legacies: oral histories, autobiographies, shared memories, works of art and music, publications, human organ donations, endowments, objects of significance, written histories, and philanthropic causes.

Legacies are identified and shared best as one approaches the end of life. According to Erikson, "Each person is a link in the chain of generations and as such, may identify with generational accomplishments." An old person may feel himself as a significant part of a generation that survived the Great Depression of 1929. A middle-aged person may identify with the generation that walked on the moon. Those years of youthful idealism are impressed in one's memory by the political or ideological climate of the time.

There are many ways that one's legacy is expressed through the development of others. Here are several examples that illustrate how one's legacy can be expressed.

First Illustration

John, an aged man cried as he talked of his grandson's talent as a violinist. They both shared their love for the violin and the grandfather believed he had personally contributed to his grandson's development as a budding musician.

Second Illustration

A retired professor spoke of visiting his son in a distant state and hearing him expound ideas that had been partially developed by the professor and his father before him.

Third Illustration

Aunt Martha worried about preserving the environment for future generations, so she took her niece on a nature walk to stimulate her interest in birds, plants, and small creatures. She also donated land for a future natural park. People who amass large fortunes and allocate to certain funds for endowment of artists, scientific projects, and intellectual exploration are counting on others to complete their legacy. Following are several suggestions for assisting an elder to identify and develop their legacy:

- Find out their lifelong interests and discuss them with appropriate individuals
- Establish a means of recording these interests for posterity
- Record legacies with copies distributed and review for future referral

It is gratifying to an elderly person if a legacy can be converted into some calculable form, thus ensuring that it will not readily be dismissed or forgotten. I have, at this point, offered several mechanisms that can be employed for establishing a credible legacy. One final mechanism is a series of questions to help the elderly prepare a legacy, but only if he or she is ready to do so.

1. Have you ever thought of writing an autobiography?
2. If you could leave something to the younger generation, what would it be?
3. Have you given thought to the impact your generation has had on the world?
4. What has been most meaningful in your life?

These suggestions should readily stimulate ideas for a spontaneous discussion which is far more valid in an interpersonal way than merely parceling out cherished items with no thought as to who receives them.

One's personal items are highly charged with memories and meaning and transferring them to friends and kin can be an emotional experience. Most important, they should never be dispersed without the owner's knowledge. It is vital that people approaching the end of life be given full opportunity to appropriately distribute their important belongings to those whom they feel will most cherish them and think about their significance.

On a personal note:

- The golden years, a phrase frequently spoken by an older population can be a positive experi-

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Industry in crisis

A state-by-state rundown

Nearly every nursing home (99%) and assisted living facility (96%) in the U,S, is facing a staffing shortage according to ACHCA. The following is a summary of the situation in the New England states.

Connecticut

We are currently in one of the worst healthcare staffing situations of my 45+ years in the industry.

The licensed nurse cohort continues to age, and Connecticut does not have the capacity to train enough new nurses. Staffing agencies that are unconstrained by government reimbursement are proliferating exponentially to the point where the presidents of the Connecticut Association of Health Care Facilities/Connecticut Center for Assisted Living and LeadingAge Connecticut have asked the State Attorney General for an investigation into their pricing practices. Most importantly, COVID-19 has taught healthcare employees that they work in a potentially life-threatening environment and that there are other opportunities for them at similar or better wages.

Although Connecticut has one of the highest staff vaccination rates in the country, the loss of even a few healthcare workers because of vaccination mandates can have adverse consequences. We hear anecdotally of facilities turning down resident admissions due to insufficient staff to care for them.

On a positive note, the Governor issued an executive order reinstituting the Temporary Nurse Aide program in September. The order also includes a process for transitioning to a certified nurse aide. The Statewide Post-Acute Care Workgroup, a collaboration of educators, providers, and policy makers, are meeting routinely and trying to find solutions for our healthcare workforce shortages as well.

We are hopeful.

— Richard C. Brown, CNHA, FACHCA, director of member services, Connecticut Association of Health Care Facilities

Rhode Island

The primary predicament we face is a massive and growing labor shortage. We currently have approximately 1,920 open positions among Rhode Island's nursing facilities.

It is safe to say that none of our member nursing homes will be in compliance with the well-intentioned minimum staffing legislation passed last year–unless we seriously reduce the population in our homes.

Many staff have simply burnt out, are afraid of COVID, lack childcare, or have sought jobs in other fields. From August through October, we lost more than 300 staff members as a direct result of the vaccine mandate that took effect in October.

There are a number of reasons why nursing facilities cannot compete the way most businesses can, including:

- Facility revenues are largely reimbursed by governmental payers–primarily Medicaid. We don't set the rate, the state does.
- In the last ten years, Medicaid reimbursement has increased by 10%, while expenses increased at least 25% as the direct result of budget cuts–and that is pre-pandemic.
- The recently enacted Minimum Staffing Statute is set to take effect on January 1, 2022. According to the Department of Health's own calculations this unfunded mandate will cost $18.8 million (after the $2.5 million provided for in the bill is factored), during 2022 alone. When fully implemented, the unfunded portion of this bill will be $47 million annually.

Given the current labor shortage, the vaccine mandate, and chronic underfunding by Medicaid, many nursing facilities are already self-limiting admissions because of staffing challenges. For these reasons, all facilities will be unable to comply with the upcoming staffing mandate metrics.

Among the major challenges we face are:

- Lack of sufficient applicants, including RNs, LPNs, CNAs, and ancillary staff such as dietary, activities, housekeeping, and laundry
- Strong competition in other areas of the economy
- Limited availability of certified nursing assistant testing sites
- Facilities are being asked to do the impossible and, when they are unable to do so, the consequences include Medicaid claw-backs, withholding Medicaid payments, admissions freezes and, according to the Department of Health, over $8 million in fines in year 1.

In essence, the Rhode Island nursing home industry is in a full-blown crisis, and there does not seem to be a solution in site. Over the next 20 years our eighty-five plus population will be doubling, and the need for skilled nursing and all other components of the long-term care continuum will rise exponentially with that increase. We can no longer kick the can down the road. The time to act is now.

— John E. Gage, MBA, NHA, president and CEO, R.I. Healthcare Assn.

Maine

Maine has lost approximately a dozen nursing homes over the past 10 years, each closure with its own set of determining factors. Out of 93 nursing homes in Maine as of October, five recently announced that it would be closing. Additionally, one assisted living facility has also announced its intent to close. While the causes for closure may be unique to each home, every facility faces similar underlying challenges.

In general, Maine's nursing homes have been influenced by a perfect storm. We have mostly small nursing homes that serve large numbers of MaineCare beneficiaries. Our residents require a higher level of care than in most other states. Historically, MaineCare (Medicaid) rates have not kept pace with increases in wage and benefit costs, and COVID-19 has exacerbated the preexisting workforce crisis.

The closure of a nursing home has a devastating impact on a local community, cre-

Continued on next page

The hits just keep coming

by Bruce Glass, MBA, FACHCA

The focus this issue is on staffing, which is reaching crisis levels throughout senior care. In case you were hoping for miracle solutions, alas, none are to be had herein. Hopefully you will find some useful information from some knowledgeable people. Irving Stackpole, Kris Mastrangelo, and Ralph Peterson have thoughts worth considering.

However, we are really in need of long-range approaches to a problem that is more likely to increase than to disappear.

I have some suggestions that may or may not be possible, but should be considered:

As an aspect of the pandemic, each state has received a windfall of federal money which can be used as needed. Part of that should be dedicated to state-operated and funded CNA training. A paid two-week program could not only include the mandated 75 hours, but also some life skills. Ideally it would also include some short-term assistance with childcare.

On that topic, subsidized child care for workers would be immensely valuable for low-income workers across the board.

Even with this, there would still be a need for additional CNA, dietary and housekeeping staff.

Any immigration reform should add a provision for guest workers. These non-citizens would be legal, trackable, and would contribute to Social Security and taxes. Guest worker programs have worked well in Germany and other countries with labor shortages.

As for nurses, an expansion of H1B and H2B visas would be an important way to recruit more licensed nurses.

These should be priorities for AHCA and LeadingAge.

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.

Industry in crisis

Continued from preceding page

ating job loss, and reduced access to long-term care services close to home. Today, finding placement may be quite difficult as providers grapple with decreased capacity and staffing due to COVID-19.

The staffing crisis is the worst that it has ever been. In a recent survey, 94% of facilities indicate they are experiencing a staffing shortage and nearly 50% report a crisis level with numerous openings and few-to-no qualified applicants. Maine's health care worker vaccination requirements also took effect on October 1, but implementation was ultimately delayed to October 29th. We estimate that approximately five to seven percent of the long term care work force left as a result of the mandate.

The Maine Legislature and

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NAB is evolving. Will CMS follow?

by Richard Gamache, MS, FACHCA

The National Association of Long Term Care Administrator Boards, or NAB, as they're more informally known, is keeping up with the changes in our time-honored and noble profession, not only with updated exams, but also with a range of support services for future and current administrators.

Today, a candidate sitting for the exam will likely encounter as many questions about culture change and person-centered care as those regarding the NFPA and the latest life safety code. Through a partnership with the ACHCA, NAB will assist anyone who is seeking an AIT opportunity by connecting them with ACHCA resources. NAB also keeps a current list of all colleges and universities that are NAB-approved, meaning the education provided to students will enable them to pass the administrator boards. If one has questions regarding the qualifications for licensure in a specific state, NAB can help.

As we all know, NAB maintains a CE registry, so that continuing education can be found in one online file. All states require licenses for nursing home administrators, some are trending towards licensing leaders for AL, Independent Living, and Home and Community-Based Services (HCBS) as well.

NAB determined that 4 of the 5 Domains of Practice apply to leaders of all types of residential and home care for elders. As a result, a new qualification, Health Services Executive (HSE), which may provide more flexibility for long-term care leaders, is available at NAB, and is likely to be required by states soon. Twenty states currently accept the HSE for licensure as a long-term care administrator.

An excellent new book, "The Health Services Executive; Tools for Leading Long-Term Care and Senior Living Organizations," written by longtime ACHCA members Keith Knapp and Doug Olson, has been published this year by Springer Publishing, detailing what every future (and current) administrator needs to know to be successful.

From time to time, NAB systematically evaluates the skills and knowledge an individual needs to be successful as a long-term care administrator.

The Domains of Practice are:

- Customer Care, Supports and Services, which covers clinical care and person-centered care
- Human Resources Management, which encompasses recruitment, retention, interviewing skills, performance appraisals, and training methods.
- Financial Management, which focuses on managing cash, operating and capital budgets, and risk management.
- Environment, the only domain that doesn't apply to Home and Community-Based Services (HCBS), covers the Life Safety Code, NFPA, safety, and

Continued on next page

Will CMS keep up with the times?

Continued from preceding page

regulatory compliance.

- Leadership, which is all-encompassing. Knapp and Olson devote 5 chapters to it in their book. The NAB exam looks to measure proficiency in marketing, strategic planning, critical thinking, change management, leadership, quality measurements and more.

The skills and experience that long-term care leaders possess will continue to be in high demand for the foreseeable future, although long-term care is likely to evolve dramatically over the next several decades. It may not look or feel the same ten years from now, but the same skillset will be needed.

For new administrators entering the field now, they are jumping into what has been, arguably, the most difficult time to be a long-term care administrator in our history. The perfect storm of a pandemic, staff shortages, and financial shortfalls, have created an almost untenable situation for even the most seasoned and savvy long-term care leaders.

Our future requires new thinking, and a complete reimagining of congregate care models. Private rooms, access to outdoors, fresh air, and familiar caregivers who are not chronically working shorthanded and running between jobs because they cannot afford to live on current wages, must be part of the future of long -term care.

Newly licensed administrators will ride waves of change toward a more balanced system of Long Term Services and Supports. Indeed, HCBS have begun to grow, and are currently receiving support from elder advocates and elected officials, state by state and at the federal level.

Unfortunately for those of us working on the congregate side of long-term care, those same advocates and elected officials are prescribing the wrong treatments in a misguided effort to "fix" long-term care. A combination of mandated nursing staff levels and more regulatory scrutiny, especially on infection control, including fines, are being teed up to address the flaws in our broken system.

We all agree that the system needs "fixing," but in typical fashion, CMS will impose remedies that will only serve to exacerbate the perfect storm of problems we battle every day. Growth will happen in HCBS, but it is myopic not to support the

We all agree that the system needs "fixing," but in typical fashion, CMS will impose remedies that will only serve to exacerbate the perfect storm of problems we battle every day.

evolution of congregate care as well, since some form of it will always be needed.

In 2020, COVID-19 swept through nursing homes across America not because we are all terrible practitioners of infection control, but because nursing homes were never designed to mitigate the spread of infection. Double rooms, shared bathrooms, and a dormitory-style shower at the end of the hall are sure-fire ways to spread germs. Add to that a workforce that travels from one community to the next, out of necessity, because their wages are below the poverty level, and you have a recipe for disaster.

We need architectural change, and a gravitation towards smaller house models, but we need funding to do it. Forgivable or low-interest loans would be a great starting point for our government if the goal is to transform the system.

When all is said and done, workforce issues may end up costing more lives than the coronavirus, as no one wants to do this type of work for current salaries when there are easier jobs with higher wages in every location.

Mandated staffing levels, however, are a short-sighted solution. First, the "ideal" of 4.1 nursing PPD is based on a 20-year-old study. Since then, research has been less conclusive regarding the impact of increased nursing staff on quality.

Second, it is challenging finding anybody available to work. Nursing agencies are paying nurses $90 an hour, and hospitals are offering sign-on bonuses of over $10,000. We simply can't compete because most of our residents are Medicaid recipients, and we are being underfunded by poor rates of reimbursement.

Further, 4.1 only addresses nursing, and one of the broken systems within long term care is that we lean heavily towards a medical model, when outcomes have proven to be better with a more balanced psycho-social model. We may see a trend whereby activities and social service staff become scarcer as leaders make tough economic decisions brought on by mandated nursing staffing.

If we were able to find enough nurse to fill our vacant jobs, we might have enough nurses. The real problem is that half of the work that nurses do is not nursing, it's compliance.

CMS needs to get with the times and adopt a new approach. They can (and apparently will) regulate us until the cows come home, and we will still have infections that spread because of our old physical plants and workforce issues.

Why can't CMS evolve and move forward? Our profession has pulled ahead of them, and the standards needed to pass the NAB exam are preparing long-term care leaders for the future. Currently, CMS has no plan for long-term congregate care, and we need their help to make the changes necessary to continue our sacred work.

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

Ornstein

Continued from page 6

ence for everyone who pursues it. (Build a legacy while it is in your purview to do so!)

- The golden years offer a potentially qualitative life that was once consumed with day-to-day problems and issues. You overcame many of these problems. (Therefore, consider creating a legacy!)
- The golden years can sometimes be elusive to those remaining years. (A good time for establishing that legacy!)

A brief anecdote: Mary was 93 years old when she passed. Still, she was known to have an uncommon yet practical philosophy about the legacy she was leaving behind. These were Mary's words. "At 93 I am both frail and tough, and toughness seems to dominate. This is my legacy." This truly was Mary's legacy. My advice to all of us is, consider adopting Mary's philosophy. It holds great possibilities.

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

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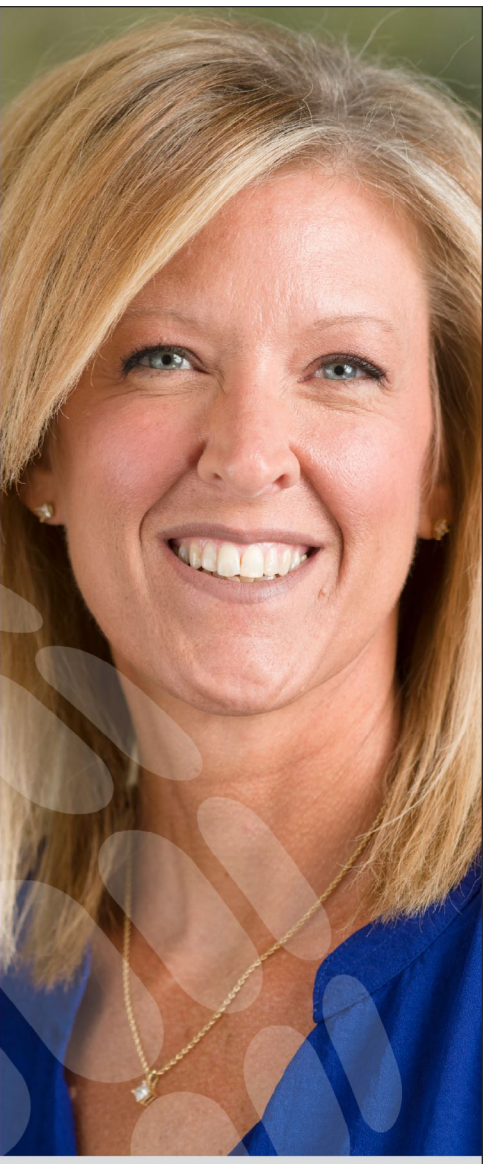

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Feeling valued

by KR Kaffenberger, PhD

Robyn Stone and Natasha Bryant of the LeadingAge LTSS Center @UMass Boston have published a white paper, "Feeling Valued Because They ARE VALUED," to present a long-range vision reimagining the professional direct care workforce across all long term care settings. They say that it presents a federal policy and advocacy agenda to pursue important improvements in LTSS for the long term care community. Although states are different in the way they deal with the long term care workforce we should also consider using it for guidance in state efforts.

The long term care workforce includes nursing assistants, personal care aides, and home health aides. These workers are professional care givers. Many of us are informal caregivers or depend upon friends and relatives who provide caregiving in an informal manner. The greatest part of caregiving for disabled individuals in the United States is provided by informal care givers. However, the professional workforce cares for millions of disabled people and will need to care for many more in the relatively near future.

The COVID crisis has reduced the number of workers immediately available for this work. In many ways, the pandemic has made their work more difficult and more important. In the short term these circumstances have led to some increase in pay for some direct care workers in some states. But as noted, the burdens of the work have been exaggerated which leads to the continuing truth of the statement:

The authors highlight five elements that should be present for professional care givers to give them standing like trained professionals in other fields. They should:

1. Receive high quality competency training
2. Earn a living wage with meaningful benefits
3. Have good working conditions and skilled supervision
4. Have a variety of career advancement opportunities
5. Be respected and appreciated for their work by employers, care recipients, and others

Stone and Bryant outline six key steps or strategies to move the direct care workforce along the path to these improved circumstances and conditions.

1. Expand the entry of caregivers by recruiting those not currently targeted and by improving immigration policy
2. Enhance education and training, both providing more at the outset of a career and along the way
3. Facilitate career advancement
4. Increase compensation
5. Prepare universal workers. By using competency cross-training, a single license should permit work in multiple settings.
6. Reform the LTSS financing system by developing insurance income to augment existing means of reimbursement.

These strategies dovetail with the elements of employment that long term care workers should enjoy. The authors go on to present ideas about how the strategies might be pursued.

Workers should be recruited who are recent high school graduates, who are displaced from other work, and who are older and want a different career. In addition, long term care work should qualify for guest worker visas as agricultural and hospitality workers have done for years. Cultural exchange visas such as those for au pairs could be used for personal care assistants. Something like the EB-3 program could be used to permit the entry of professional care givers.

Training and education need to be enhanced to include a broader range of competencies which are proven by practice, examination, and other measures. They may include clinical, management, and communication skills. Models exist for these kinds of efforts. Funding sources should encourage such efforts through financial investment.

Career ladders direct caregivers to advance through a narrow set of steps, but career lattices could offer caregivers ways to approach other responsibilities and other long term care professions as possible areas for advancement. Apprenticeships is another tool that could help develop career lattices and recruit varied workers.

Increased compensation is a key to bringing and keeping workers in the long term care workforce. During the pandemic, 36 states took actions to temporarily increase pay for long term care workers. Such increases need to take place in other states and be made permanent. Targeting increases only to long term care payroll has been problematic. Too often targeted increases have required increased bookkeeping and have done little to improve the work environment beyond pay. Some states have found ways to increase Medicaid and pay rates in ways (like quality performance) that political leaders find attractive.

Several states have developed competency-based training standards designed to prepare individuals to work across all LTSS settings as "universal workers." The utility of such a step is obvious both for workers and trainers. Workers could move across settings as needed, and trainers would be delivering a uniform training regimen to all direct care workers.

Over the years there have been several different schemes recommended to enhance public payments for long term care. With Medicaid paying for 52% of care, often near or below costs, some other source of revenue is needed. Many of the steps that will need to be taken cannot be accomplished without such an enhanced revenue structure.

This article paraphrases the work of Stone and Bryant. Their white paper is available through the hypertext in the first paragraph. They point out as Irving Stackpole and others have that the 85-plus group, the neediest age group for care, is expanding very rapidly. They also point out that the existing sources of workers is becoming diminished.

KR Kaffenberger

The situation is not going to get better by itself. Here the authors give us a knowl-

Continued on next page

"You can keep this job you fat jerk," she said, punching me in the throat. "I quit!"

For those of you who know me, you have probably heard me tell this story. I wrote about it in my first book, aptly titled: "Managing When No One Wants to Work" (Four-Nineteen Press 2014).

I had been managing housekeeping departments in long term care homes for more than ten years at the time, and to say that I was at my wit's end would have been an understatement. It didn't seem to matter what I said or did; I could not get people to show up for work. I was always short staffed.

To be honest, I thought it was my industry. Let's face it: There aren't a lot of kids out there who dream of one day becoming a housekeeper. What I realized, however, was that it wasn't just my industry; everyone was struggling with being short staffed.

In 1961, famed psychologist, Abraham Maslow, (the guy who established the "hierarchy of needs" model) published a book, "Maslow on Management" (John Wiley & Sons, Inc.).

In his book, Maslow compared (1960s) knowledge workers to volunteers and made a startling prediction: With the coming age of the knowledge worker (i.e., employees whose skills are transferable from one job to the other), he said, there would be a day in the very near future where it would be increasingly difficult for employers to not only attract employees but keep them as well.

He reasoned that when an employee has transferable skills (think of a licensed or certified nursing assistant), it would be easy for them to switch jobs, and they would without hesitation. As a result, Maslow believed employers would be competing with one another not just for customers, but for employees as well.

The day has certainly arrived.

However, instead of competing for employees with one another, employers are finding many employees look at work as unnecessary and superfluous. There is another entity at play here, making it possible for many potential employees to bow out of the job market all together.

What can we do?

Maslow reasoned that the only way to retain a knowledge worker was to treat them as if they didn't need the money. That is, rather than treating them as traditional employees, where both parties have needs being met by the other (you need the employee, and they need the money), you may need to treat them as you would a volunteer.

The question becomes: How do you treat a volunteer?

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

A state-by-state rundown of the staffing crisis

Continued from page 8

the governor appropriated $123 million in supplemental support to long term care facilities in June. The financial support is welcome as MHCA continues to see the additional impacts of COVID-19 fatigue, the Delta variant, and a provider community stretched thin.

—Angela Cole Westhoff, president and CEO, Maine Health Care Association

Massachusetts

If you asked LeadingAge MA members what keeps them up at night, right behind guarding against COVID outbreaks, most would respond that they are worried about being able to adequately staff their community. Prior to the pandemic, when unemployment was at an all-time low, many providers were challenged with recruiting enough CNAs. Unfortunately, the pandemic has significantly exacerbated that problem, and staffing shortages are now at a crisis level in Massachusetts.

More than 20 months into the pandemic, with no clear end in sight, employee burnout in long term care remains high. With most sectors in our economy facing staffing shortages, the competition for labor is stiff. Aging services providers are not just competing with hospitals and other health care employers who are able to pay higher wages, they are also competing with companies such as Amazon that advertise better wages and flexible hours. Positions in many other industries do not require staff members to wear PPE and submit to weekly testing, requirements that are still in place for those working in long term care.

In early August, Massachusetts announced a vaccine mandate for long term care, requiring all personnel that do not have an exemption for medical reasons or sincerely held religious beliefs to be fully vaccinated against COVID-19 by October 10. While there has been some loss of staff members who refused to be vaccinated, overall, resignations have been low. Even though the vaccine mandate has not had a significant impact on retention, it has created yet another barrier to recruitment. Since all new hires must be fully vaccinated before they can begin work, long term care providers may find themselves at a disadvantage when bringing new staff on board. Even if prospective new hires are willing to get vaccinated, they would be required to wait to begin work if they are not two weeks beyond their vaccination regimen. With ample other opportunities for employment, this wait could be more than many would be willing to accept.

Providers are desperate to fill shift,s and the use of temporary agency staff is high despite the significant downsides of high cost and the unreliable nature of the care provided.

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Feeling valued

Continued from preceding page

edge base and ideas that can be used to guide advocacy and management decisions to save the LTSS workforce future from seemingly inevitable failure. Please consider looking at the larger document and trying to figure out what might be done in your company or in your state to move forward. The authors have a national scope, but the states are where much of the future is being developed. And the New England states are where we are.

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

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Staffing crisis

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LeadingAge MA members that had never utilized agency staff in the past have been forced to do so. Many providers have also turned to the state's rapid response team (RRT) for assistance when staffing levels have become truly unsafe.

The workforce challenges that long-term care providers are facing cannot be looked at in isolation. The impact of these staffing shortages is having ramifications across the health care sector. Facilities with otherwise available beds are left unable to admit residents from the hospital when they do not have the necessary staffing to provide care. Our healthcare system is dependent on high quality, well-staffed long-term care facilities, and critical staffing shortages are standing in the way of our ability to care for all those in need.

– Elissa Sherman, PhD, president, LeadingAgeMA

New Hampshire

As a dinosaur whose first high school job outside of a paper route was washing dishes in a pizza restaurant for $3.35 an hour, I have watched with wonderment as fast-food restaurant wages have risen dramatically since the pandemic began. The other day I drove by a Seacoast McDonalds with a banner advertising $800 a week – that's $20 an hour!

While I am happy for the workers, that banner symbolizes a fundamental labor market change that many businesses may not survive. As I represent nursing homes and other long-term care facilities, I am particularly concerned for them, especially those operating within the confines of Medicaid reimbursement. All facilities have dietary departments, and Medicaid means would not allow them to pay $20 an hour to kitchen staff. Indeed, that is beyond the limits of what most facilities can pay a licensed nursing assistant, who must complete 100 hours of training and pass two criminal background checks before working.

Price inflation is also running high, with the U.S. Bureau of Labor Statistics finding food costs for our region up 4.9% in October over a year's time, and I need not get into the stupendous increase in fuel costs of which we are all painfully aware. Beware the winter.

As it did in 2020, with Coronavirus Aid, Relief, and Economic Security (CARES) Act funding to sustain long-term care, the state recently pulled a rabbit out of its hat and found another $11.5 million in CARES funds to provide grants to nursing homes and the Cedarcrest Center for Children with Disabilities. Providers are very grateful to Governor Sununu for proposing this critical aid, and to the bipartisan unanimity on the Executive Council and Joint Legislative Fiscal

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NURSING HOME DEFICIENCIES BY STATE

State	Deficiencies
CT	8.4
ME	5.9
MA	9.9
NH	3.7
RI	6.9
VT	4.1

Due to the pandemic, numbers are from 2019. National average from that year is 8.3.

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Staffing crisis

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Committee in approving it.

Yet we are we are still left with a conundrum: Where are all the workers? While the daily net migration of thousands of Granite Staters to Massachusetts to work in the health care and social services sectors was painful pre-pandemic, it is even more so now when we simply cannot find the home-grown talent to hire – especially in the licensed categories.

The state itself has been beset, soliciting proposals to find a staffing agency that can "secure Temporary Staff to support a variety of public health programs within the New Hampshire Department of Health and Human Services." This was on top of an ongoing state effort to assist the state's health care providers by contracting with a recruitment firm that will "engage in national and international recruitment with the goal of permanently relocating healthcare professionals to New Hampshire."

We can only hope the state has success in both efforts, because we need the state to continue being at the top of its game in fighting COVID-19, and we need a larger workforce for health care providers to tap

into. The workforce alternative has been price-gouging piracy where providers must compete against one another, and those in other states, for workers provided by out-of-state staffing agencies. As the American Health Care Association noted in a letter to the Federal Trade Commission, "providers have little choice but to pay the exorbitant prices, and hope that the agency does not poach their staff once in the building."

One-time federal funds are a bit of a shaky platform to build systemic change, but there are some solid health care infrastructure investments the state can make through its American Rescue Plan Act funds that would bear results down the line. We look forward to seeing continuing innovation on the part of a state that has been truly helpful during the darkest times imaginable for health care.

– Brendan W. Williams, MA, JD, president/CEO, NH Healthcare Assn.

The C.A.R.E Expert on quality measures

Continued from page 3

lier in the Nursing Home Care Compare and the Provider Data Catalogue (data.cms.gov) than the measures for the transfer of health information:

- The #15 SNF Healthcare-Associated Infections (HAI) requiring Hospitalization provider preview reports begin in January 2022, and data is publicly reported in the April 2022 Care Compare refresh.
- The #15 SNF Healthcare-Associated Infections (HAI) requiring Hospitalization measure will be publicly reported with the October 2022 Care Compare refresh.

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

SNF Quality Reporting Program (QRP)

	LUCKY 13 INCREASES TO 15	SOURCE
1	One or more falls with major injury–long-stay (NQF #0674)	MDS Based Long-Stay Public 10.24.2018
2	Admission and discharge functional assessment & care plan that addresses function (NQF #2631)	MDS Based Public 10.24.2018
3	Drug regimen review	MDS Based Public 10.28.2020
4	Changes in skin integrity	MDS Based Short-Stay Public 10.28.2020
5	Change in self-care (NQF #2633)	MDS Based Short-Stay Public 10.28.2020
6	Change in mobility (NQF #2634)	MDS Based Short-Stay Public 10.28.2020
7	Discharge self-care (NQF #2635)	MDS Based Short-Stay Public 10.28.202
8	Discharge Mobility (NQF #2636)	MDS Based Short-Stay Public 10.28.2020
9	Transfer of health information to provider PAC*	MDS Based
10	Transfer of health information to patient PAC*	MDS Based

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	LUCKY 13 INCREASES TO 15	SOURCE
11	COVID-19 vaccination coverage among health care personnel HCP	Claims-Based CDC NHSN
12	Medicare spending per beneficiary	Medicare Fee-For-Service Claims-Based Public 10.24.2018
13	Discharge to community	Medicare Fee-For-Service Claims-Based Public 10.24.2018
14	Potentially preventable 30-day post discharge	Medicare Fee-For-Service Claims-Based Public 10.24.2019
15	SNF health care associated infections (HAI) requiring hospitalizations	Medicare Fee-For-Service Claims-Based

*Data collection for SNF QRP Quality Measures #9 and #10 will begin on October 1 of the year that is at least two full fiscal years after the end of the COVID-19 PHE. To reiterate, these do not take effect for at least two full years after the end of the PHE

The Marketing Guru

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gree to which a service is free of controllable defects;" preventable turnover is a controllable defect).

3. Recruit relationships

Referring to suggestion number one (above), operators can enhance recruitment success by leveraging relationships between and among current employees and others in the community. Leveraging existing staff by incentivizing/encouraging them to inquire among their families, friends, and acquaintances is the best way to recruit in this macroeconomic environment. We certainly cannot compete on wages, so we must compete on other factors; work with people you like, and like the people you work with (bad grammar, but you get the point). Systematize onboarding with relationship strengthening; build this into the very first workday and create expectations around relationships, not just tasks. Also, at the simplest level, incentivize employee referrals. These programs need to be carefully developed to prevent backlash among existing employees who may not get the incentive packages that newer employees are receiving, conflicts with unions, and other dimensions.

4. Resist the urge to bonus

Recruitment & hiring bonuses are being widely used in many service and light industry businesses to attract highly mobile professionals, especially in high-tech and knowledge-based sectors. Such recruitment bonuses are also being brandished by hospitals and others in healthcare. This is categorically bad for everyone in long term care! The research about this is clear: The same people who "hop" for recruitment bonuses will hop again leaving you short-staffed and short-changed. Recruitment bonuses are a race to the bottom. Discuss this with other, sympathetic operators in your marketplace area, and create an understanding and shared set of principled recruitment guidelines. This requires patience; watching nurses leave for five figure recruitment bonuses is difficult. Research and experience show, however that these incentivized tenures simply don't last.

Basically, the way to keep the Grinch away this season is to: 1. Close the back door so he can't get in; 2. Pay careful attention when anyone does leave; 3. Love and cherish whom you have, inviting them to invite others, and; 4. Avoid trying to buy-off the Grinch.

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SEEKING EDITORIAL CONTENT

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The New England Alliance Conference Calendar

IN-PERSON CONFERENCES!

Winter Conference & Annual Meeting

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Please be mindful of the hotel room reservation cut-off deadline: WEDNESDAY, DECEMBER 15th, 2021. We would like to encourage all conference attendees and representatives who have not yet made room reservations to call the Woodstock Inn & Resort's reservation number at (800) 448-7900 to do so. Please identify yourself as part of the New England Alliance group to receive the special room rate. Rooms are $249.00/night plus taxes.

Tentative Conference Seminars

Larry Vernaglia, Foley & Lardner LLP

"Recruitment and Retention: Understanding the Healthcare Workforce" - Maureen McCarthy, Celtic Consulting

Kris Mastrangelo, Harmony Healthcare International

"Riding the Wave in the Future with Analytics + Strategic Approaches to 360 Degree Census Recovery"
- Elisa Bovee, HealthPRO Heritage

Spring Regional Conference

May 25 to 27, 2022 • Newport Harbor Hotel & Marina, RI

For more details: thenealliance.org

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