New England
ADMINISTRATOR

June
2023

"All good things arrive unto them that wait and don't die in the meantime."
-Mark Twain

District One
ACHCA
American College of
Health Care Administrators

THE END of the PANDEMIC

ALSO IN THIS ISSUE:

A Photographic Portrait of Rick Brown

Death with dignity in New England part two

Are med techs the answer?

Changes to Medicare Advantage Organizations

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

The Marketing Guru

The Road to Gold

Harmony Healthcare International

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

C.A.R.E.S.™
HHI C.A.R.E.S. About Care
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Capability Statement

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

Compliance
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Regulatory
Rehabilitation
Reimbursement
Education
Efficiency
Survey

Compliance

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

Analysis

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

Corporate Overview

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

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

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

NWBOC WOSB CERTIFIED

Speaking Engagements

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

National Affiliations

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

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

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Capability Statement

Audit

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

Regulatory

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

Rehabilitation

Clinical, Financial and Operational Consulting
Program Development
Therapy Staffing

Reimbursement

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

Education (live, remote, public and private)

Certification and Competency Programs
Seminars
Symposium

Efficiency

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

Survey

Accident and Incident Investigation
Adverse Events Focused Survey
Expert Witness Services
Facility Assessment
Five Star Quality Rating System
IDR (Informal Dispute Resolution)
IIDR (Independent Informal Dispute Resolution)
Infection Control
Mock Dementia Focused Survey (Two Days)
Mock MDS Focused Survey (Two Days – Five Days)
Mock Regulatory Survey
Plan of Correction Development
Policy and Procedure Review and Development

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ANCC American Nurses Credentialing Center

Section GG and therapy documentation

Top 19 things to know

by Kris Mastrangelo, OTR/L, MBA, LNHA

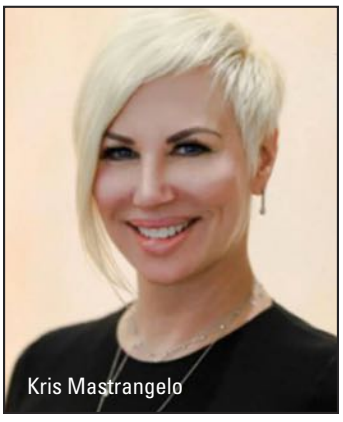
This article is intended to provide education and clarification on the purpose, the deficits, and the coding parameters for Section GG. In addition, I offer suggestions that healthcare providers can implement to prevent further damages resulting from the imperfect Section GG coding system.

Through voluminous medical record reviews and appeal letter preparation, Harmony Healthcare International has uncovered that the Section GG coding system erroneously displays patient/resident outcomes secondary to the vagueness of the system. Provider quality measure outcomes and provider quality reporting program data are misrepresented. In addition, the Section GG coding system is threatening reimbursement under the Medicare Part A payment system during governmental audits, such as TPEs and UPIC reviews.

HHI strongly recommends that providers immediately assess their current documentation structure in relation to Section GG coding protocols.

Section GG's purpose

Section GG is used in healthcare settings to assess functional abilities and care needs of patients. Its purpose is to



Kris Mastrangelo

provide a standardized, comprehensive assessment of patients' functional abilities related to self-care and mobility. Specifically, Section GG evaluates a patient's ability to perform activities such as eating, grooming, transferring, walking, and using stairs. The information is used to develop an individualized care plan that addresses patients' specific needs and goals.

Section GG is used in a variety of healthcare settings, including hospitals, nursing homes, and rehabilitation facilities. It is important for accurate documentation and communication among healthcare providers, as well as for quality improvement and reimbursement purposes.

Quality reporting program and Section GG

Section GG is an important component of the Quality Reporting Program. The QRP is a federally mandated program that requires nursing homes to report quality measures to the Centers for Medicare & Medicaid Services (CMS). The purpose of the QRP is to promote quality care and ensure that nursing homes are meeting the needs of their residents.

The data collected in Section GG is used to calculate several quality measures that are reported as part of the QRP. These quality measures include:

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- Application of percent of skilled nursing facility patients with an admission and discharge functional assessment and a care plan that addresses function
- Percent of residents or patients with pressure ulcers that are new or worsened (short stay)
- Percent of skilled nursing facility patients with an admission and discharge assessment for pressure ulcers.

The quality measures related to Section GG of the MDS are designed to assess the extent to which nursing homes are providing quality care that supports the functional abilities and overall health of their residents. The measures encourage nursing homes to use the data collected in Section GG to develop individualized care plans that are tailored to the needs of each resident. By doing so, nursing homes can improve the quality of care they provide, reduce the risk of adverse events such as pressure ulcers, and help residents achieve their functional goals.

Section GG assesses a patient's/resident's functional abilities and goals related to mobility and self-care. There are 18 items in Section GG, which are divided into two parts: self-care and mobility.

Part 1: Self-Care

1. GG0130A Eating
2. GG0130B Oral hygiene
3. GG0130C Shower/bathe self
4. GG0130D Upper body dressing
5. GG0130E Lower body dressing
6. GG0130F Toileting hygiene

Part 2: Mobility

7. GG0171A Roll left and right
8. GG0171B Sit to lying

Continued on page 15

by Irving L. Stackpole, RRT, MEd

No one bothers to argue anymore: Nursing homes are a mess. Legacy poor houses, consumers, and their families haven't wanted to use nursing homes for almost as long as they've existed. For several years, my company conducted large-scale surveys among case managers and discharge planners across the United States evaluating their attitudes and behaviors toward (among other things) long-term care and nursing homes. The results showed that the most knowledgeable health and human services professionals in the country dreaded the idea of nursing homes. And this was long before the COVID-19 pandemic.

Here is the situation today:

- Nursing homes are unable to hire staff, are under additional government scrutiny and further regulatory pressure, and are financially unable to raise the capital to morph into the private suite, cookies-in-the-kitchen ideal.
- The cross-subsidies to income from Medicare and managed care covered residents ("Q-Mix") are less available.
- Operating costs (labor) are through the roof.

Many nursing homes are "zombies": still functioning but not able to support themselves based on operating income. The result? Homes are closing at a much higher rate than at any time in the past. This is a "fatal contraction."[1]

Year	Beds
2018	1,660,515
2022	1,614,172
Change	(46,343)

Who pays the price for this contraction–the closure of a nursing home? The people who depend on nursing homes, i.e., residents / patients (consumers), their families, and staff.[2]

The family price

Usually, when a service business closes due to changing consumer preferences, or shifting demand, consumers migrate to another business. This is much less easily done in the market for nursing homes because the market is driven by need, not preference, and / or by third-party direction. So, when a nursing home closes, the burden of finding an alternate falls most heavily on the family. The family's "cost" associated with finding another nursing home is measured in the indirect time and effort as well as in the anxiety this disruption produces.[3] These costs are significant.

Families need to "process" the pending eviction, locate alternatives, and residents must be relocated, which has a significant indirect economic cost. Families, of course, bear the overwhelming share of this burden.

Using the most conservative estimate of closures, there were 129 nursing homes reported closed in 2022. With an average number of 129 beds, that represented 12,900 beds lost.

By these estimates (again, these are very conservative) there were 9,675 families forced to scramble to find another suitable destination residence. If we assume that the time required to navigate and negotiate the relocation to an alternate nursing home between 25 and 80 hours, it is estimated that these families spent 507,938 hours, or 254 work years on the arduous task. These are large numbers, and do not even take into account the anxiety and emotional disruption resulting from the evictions from closures. The loss of productivity and the emotional cost should get everyone's attention. Why is no one paying attention?

Right-sizing

One of the questions that emerges regarding nursing home closures is: "Aren't these closures the result of 'right-sizing,' when the supply exceeds the demand?" In certain urban marketplace areas, this makes sense. If the number of nursing home beds in an urban area exceeds the market demand, occupancy will also decline and eventually drive the home out of business. However, recent and current nursing home

Continued on page 18

Irving L. Stackpole

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The other side of COVID-19

by Betsy Mullen, RN MS LNHA

We heard lots of stories about healthcare workers rising to the occasion throughout the pandemic. Many were memorable and, surprisingly, heartwarming. Case in point: A husband and wife, married for 76 years, were living in a Massachusetts nursing home when the husband contracted COVID. The family made the difficult decision not to separate the couple and let them stay together. They both became very ill and were put on hospice services. Intuitively they knew what was happening and asked nothing more than to hold hands at the end. With their beds pushed as close as possible, the hospice nurse sat between them and connected their hands. They passed a few hours apart.

This story, told by a Legacy Lifecare nurse, embodies the indomitable spirit of healthcare workers during the height of COVID-19. In March 2020, life changed substantially for employees across our organization as well as healthcare staff throughout the country. Employees found themselves working more than 80 hours per week on average. They worked nonstop for hours on end, many isolated from families and friends. Their contributions far exceeded expectations.

There were so many changes. Staff uniforms now included PPE gowns, gloves, shoe covers, and goggles. Employees looked like they landed on the moon. Yet they all looked beautiful to the residents and coworkers. Wearing a mask didn't deter from smiling faces. This lasted until May 12, 2023, the day the mask mandate was lifted. "Now I remember what you look like without a mask!" was a common sentiment.

COVID 19 devastated nursing homes with illness and death in unheard of numbers. Nursing homes were known as the "villains" of healthcare. In reality, countless numbers of individual teams in this setting became the angels of healthcare to residents, families, and to each other. Our staff members gave 100% plus, every single day, meeting every few hours to update, review, and make changes in their action plans based on the happenings of that day.

Local community support was a huge factor in the fight against COVID. Business owners, organizations, and corporations showed great appreciation for the staff's efforts. It was gratifying to see community support through "thank you" signs, shopping discounts, food donations, and a sense of camaraderie among neighbors. As the saying goes, "It takes a village to raise a child." During COVID, entire communities came together to let healthcare workers know they were not alone and that "we were all in this together."

At Legacy Lifecare, leaders have always been focused on the little things that make a difference. During the pandemic, this philosophy continued. There were nutritious meals for staff, countless special treats, thank you videos from management, appreciation calls, and even housing when needed. The organization implemented "wellness days," where every employee was given days off, along with a monetary gift. Staff were encouraged to take time for themselves, rest, and indulge in an activity that made them happy. Staff felt appreciated and more prepared to face the days ahead. As the PHE recedes, the need to continue this show of appreciation and gratitude is ever present.

In addition, Legacy Lifecare continues its commitment to enhancing the lives of their employees. The company grocery store, started more than fifteen years ago on the Chelsea campus, provides free groceries to employees each and every week. The program now operates on the Peabody campus and is opening in Longmeadow. Family trips are an integral part of the workplace culture, with destinations now such as Great Wolf Water Park, Encore, and past trips to Walt Disney World and Las Vegas. The organizational culture has always been to appreciate staff and their families; this is more important than ever in the post-COVID world.

Pre-COVID, many nursing home workers throughout the country were often underappreciated and all too often taken for granted. At Legacy Lifecare, these workers have always been recognized as the heroes that they are, every day, and for the differences they made in the lives of their residents and families. They show tremendous caring and KINDNESS to residents and families, and this was never more evident than during the pandemic. There was also a huge amount of caring and kindness shown to each other, which was equally important.

Today 1.3 million people in the United States reside in nursing homes. The sheer vastness of this number requires a variety of staffing positions–administrators, CNAs, nurses, admissions staff, dietary staff, housekeeping and maintenance crews, social workers, finance and administrative staff, security–departments that facilitate that our residences run smoothly and efficiently. Our employees continue to work hard each and every day post pandemic, but many people fail to recognize this fact. They do so with little fanfare and a strong sense of accomplishment and loyalty to their residents, not looking for thanks. It is merely part of their job.

What lessons did Legacy Lifecare learn from COVID-19? Staff continues to be a huge priority for the organization, investing emotional and financial resources. There is no agency staffing in Legacy affiliates. New staff members are welcomed twice monthly through orientations and one-on-one meetings. Appreciation of staff, residents, and families is key, as is frequent communication. While this was always part of the culture prior to COVID, it has now become a guiding force. The focus is truly about "people taking care of people."

The pandemic also reinforced with Legacy Lifecare the significance of efficient communication systems in terms of staff, residents, and families. The organization learned that it must continue to keep everyone informed. In fact, you can never overcommunicate. People want to be "in the loop." They want, and need, details.

Like the rest of the world, Legacy Lifecare will never forget the hard, sad days of COVID-19. Although greatly diminished, the virus is still present. The fear of illness remains real, along with the need for vigilance. And even though the public health emergency is over, it is imperative not to forget the incredible loyalty, dedication, kindness, and courage of the healthcare workers. As the leaders of buildings and organizations, it's vital to continue to recognize these unsung heroes in the buildings, our most valuable assets. Without them, there are only bricks and mortars.

Betsy Mullen, RN MS LNHA is Chief Operating Office for Legacy Lifecare, which owns or manages a number of not-for-profit facilities in MA. She is the recipient of the prestigious Pinnace Award from McKnights. She was assisted in the article by Karen Petroccelli and Debbie Weisberg.

Death with dignity in New England – Part two

by K.R. Kaffenberger, PhD

This article is a follow up to the March 2023 New England Administrator article, "Death with Dignity in New England."

Death with Dignity laws have been passed in nine states and the city of Washington, D.C. In addition, there are active efforts to provide legal support for medical aid in dying in many other states. In New England, two states, Maine and Vermont, have such laws. The other four New England states have efforts underway to provide such support through legislative change (new laws) or have had such efforts very recently.

Although these bills often encounter opposition, it is reasonable to suppose that laws for autonomy around death will continue to spread. Bills have been supported by both Democrats and Republicans. Clinical and administrative leaders of residential facilities for older people may want to start thinking about what this means for their facilities.

Anecdotally, medical aid in dying has not been widespread in SNFs or upper-level assisted living. The conditions that determine eligibility for such medical aid under existing laws may discourage their use in higher-intensity care settings, because the residents need to be of clear mind and capable of self-medication. Health care proxies are not permitted to make decisions for medical aid in dying.

It is not difficult to see that medical aid in dying will become more widespread. It may then become far more common for higher-level assisted living residents and some SNF residents to request such services. Many would be well qualified to make the necessary decisions and participate.

Existing guidance around provision of such services is often focused on the doctor-patient relationship and family support. There is little mention in most sources of institutional participation in the process. At its simplest level this may be appropriate. The patient requests medical aid in dying, the physician complies and writes the necessary prescription with appropriate directions for use, and the patient self-administers.

Everyone recognizes that this is an important process and in almost every instance there are many people affected by it. It is complex, not simple. This will be especially true in a group residential setting.

Recognizing this, the American Nurses Association has published a position statement entitled, "The Nurse's Role When a Patient Requests Medical Aid in Dying."

One of its purposes is to frame the nurse's compassionate response to such a request within the scope of practice. It goes on to say that "Hallmarks of end of life care include respect for patient self-determination, nonjudgmental support for patients' end of life preferences and values, and prevention and alleviation of suffering."

The statement highlights the fact that nurses are ethically (and legally) prohibited from administration of medications for aid in dying. Beyond objectivity, nurses have a duty to be knowledgeable about these matters, to support patients in the process, to protect confidentiality, and to be involved in policy development as appropriate.

The ANA position statement contains many elements which may help in trying to think about how to prepare a residential care facility for requests from its residents. Having some guidance and direction for staff around this important issue can encourage better care and discourage external or legal discord.

Betsy Walkerman is president of Patient Choices Vermont. When approached about death with dignity she was quick to point out that like some of the other language that is used to describe the process "death with dignity" has detractors and can lead to confusion. She thinks that the "medical aid in dying" language most accurately describes the process of a physician prescribing medicines that can allow a person to control when they die.

In her description of the work at Patient Choice Vermont and the ongoing development of medical aid in dying in Vermont two or three things stood out.

Facilities can limit the use of medical aid in dying among their patients, but for the most part it is hard to do so unless they employ physicians and may define their scope of practice. Otherwise the physician is free to determine what practice dictates in the support of the patient.

She noted that where facilities are involved in medical aid in dying, care planning is a critical tool to inform the patient and the staff about the process, alternative choices, and necessary actions. She referred to Vermont Patient Choices Clinicians Guide which is available on their web site.

Ms. Walkerman has concerns about compliance with medical aid in dying requests. She points to SNF residents who have requested cessation of food and drink. Both in cases where the resident was competent and in cases where the advance directive was clear and the health care proxy forceful, it has often been difficult to obtain compliance from SNFs. One wonders if an organization which can not comply with such requests is well prepared to deal with medical aid in dying.

Another point that speaks to more widespread availability of medical aid in dying are the many calls Patient Choices Vermont gets from out of state. Recently, Governor Scott signed into law an amendment that permits out-of-state residents to obtain medical aid in dying in Vermont. Patient Choices Vermont gets at least a call a day and often more from patients who wish to come to Vermont to autonomously control their own death.

Maine is also a leader on Medical Aid in Dying in New England. The Reverend Valerie Lovelace is the Executive Director of Death with Dignity Maine. She describes a state in which Medical Aid in Dying is increasingly used and accepted.

Like some other states the Maine Medicaid program, Maine Care, has the discretion to provide some supports and services without federal assistance. As a result, discussion of medical assistance in dying can be funded as part of a broader discussion of end-of-

Continued on page 12

PIONEERS & ROGUES

We regularly feature a New England individual whose accomplishments–good or bad–helped to shape our profession. In this issue, we feature a true pioneer from Connecticut: Rick Brown, CNHA, FACHCA.

by Rick Gamache, FACHCA

Those of us who have been members of ACHCA for many years surely encountered this edition's featured pioneer, long-time Connecticut Chapter member Rick Brown. Your recollection of him likely includes two things: First, he was almost never seen without his trademark bow tie; secondly, he was the man behind the camera, snapping photographs at American College events. Rick never had to remind his subjects to "say cheese" as he peered through the lens, because people smiled as soon as they saw him. He could light up a room with his infectious, positive spirit.

Richard C. Brown, CNHA, FACHA (retired) has contributed profoundly to Connecticut's long-term care profession in a storied career of almost 50 years.

Rick became licensed in Connecticut as a nursing home administrator in 1974, managing nursing facilities in Connecticut as large as 180 beds. He joined the ACHCA immediately and became a certified nursing home administrator and fellow in 1982. He was the Connecticut chapter president of the College in 1984 and 1985.

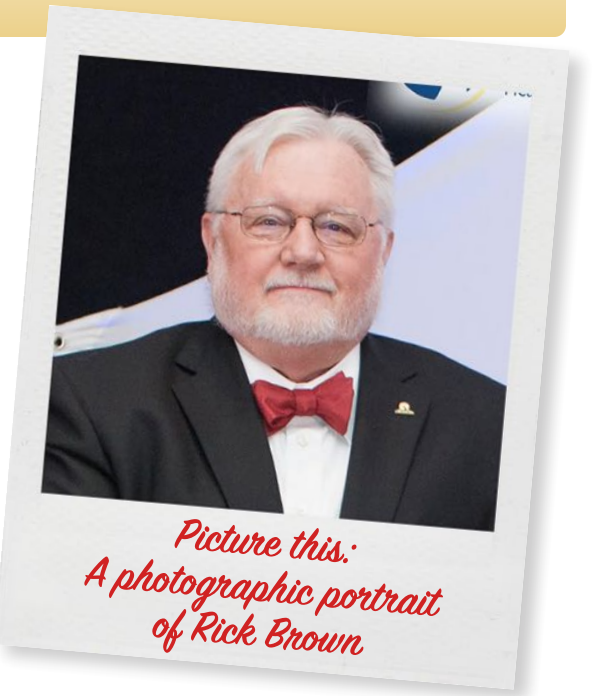
In 2016, at the College's national convocation in Philadelphia, he was honored with the ACHCA Outstanding Member Award and in 2022, at the College's national convocation in New Orleans, he was honored again with the ACHCA Distinguished Service Award.

In 1999 Rick joined the Connecticut Association of Health Care Facilities as the director of the CAHCF Preferred Services Corp. In 2003 he became the director of member services, a position he held until his retirement on April 1, 2022. In 2022, at the CAHCA/CCAL annual meeting in Mystic, CT, he was honored with the CAHCF/CCAL Lifetime Achievement Award, where Matt Barrett, the association's president and CEO, honored him by saying, "The long and storied career of Mr. Richard Brown, or his impact on his peers at CAHCF/CCAL, the elder care profession, and the American College of Health Care Administrators, here in Connecticut and across the nation, simply cannot be overstated."

Rick has done it all with distinction and elegance. He was the highly respected administrator at Summit Nursing Center in Griswold, CT for fifteen years. One of the many notable qualities that characterized his leadership style was his daily ritual of visiting staff members on all three shifts. Rick tirelessly interacted with everyone and demonstrated genuine respect for each person.

While Rick claims that he's retired, he continues to work part-time for the association and continues to contribute to the Connecticut chapter of the College.

Rick lives with his wife, Donna, in Canterbury, CT. His son, Derek, and two grandsons, Brock and Jack, live in Colorado Springs, CO.



Picture this: A photographic portrait of Rick Brown

In reflecting back on the long sweep of Rick's career, we can assume that he has taken thousands of photos at ACHCA events. But to measure Rick's broad reach on our profession, we are quite sure that there are at least as many people whose lives Rick impacted as there are photographs in his collection. Rick's influence on those who worked for and with him, along with those whom he mentored and the resident's lives that he touched, far exceed the number of faces he captured on film at annual meetings and convocations.

Thank you, Rick, for making so many of us smile.

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

SEEKING YOUR CONTENT

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Maine's Lessard elected to ACHCA chair post

ACHCA is pleased to announce its 2023 - 2024 Board of Directors. Board members were installed during the board meeting at ACHCA's 56th Annual Convocation and Exposition on Monday, April 24, in Baltimore.

Matthew J. Lessard, MS HPM, CNHA, FACHCA, Regional Director of Operations for Maine, with National Health Care Associates, was voted in as Chair. A member of ACHCA since 2005, Matthew brings over 19 years of expertise as a licensed nursing home administrator. He has served on the Education and Bylaws Committees and as District One Director.

When asked his thoughts on being elected to Chair, Lessard commented, "Today, as we emerge from the pandemic and face both new and recurrent challenges, our profession needs the college more than ever to provide advocacy, leadership, and development to support health care administrators. I am proud to be a member of the Board of Directors and serve as Chair as we embrace this defining season for post-acute care."

You can view the full listing of the Board of Directors online at ACHCA.org.

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CMS finalizes necessary changes to Medicare Advantage organizations

by Maureen McCarthy, CEO, Celtic Consulting

The Centers for Medicare and Medicaid Services (CMS) finalized and published the "Medicare Program; Contract Year (CY) 2024 Policy and Technical Changes to the Medicare Advantage (MA) Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly." Changes included in the MA final rule will impact Medicare beneficiaries in nursing homes beginning June 5, 2023.

What has long been observed by the long-term care (LTC) industry–Medicare Advantage organization (MAO) case managers requiring skilled nursing facility (SNF) MDS Coordinators to falsify the MDS assessment, MAO misinterpretation of Resident Assessment Instrument (RAI) manual guidelines to deny coding, assessment types, Assessment Reference Dates (ARDs), completion dates, and submission dates–was captured in a 2022 report (OEI-09-18-00260) by the U.S. Department of Health and Human Services, Office of Inspector General (OIG). The agency recognized that findings from CMS's annual audits of MAOs "highlighted widespread and persistent problems related to inappropriate denials of services and payment." The OIG reviewed denials of prior authorization requests and payment denials from one week in June 2019 and determined "MAOs also denied payments to providers for some services that met both Medicare coverage rules and MAO billing rules."

The MA final rule makes significant progress to address and correct concerns identified in the OIG's report. The MA final rule details constraints on MAOs, designed to protect beneficiary access to care, align coverage more closely to traditional Medicare, and strengthen beneficiary protections related to MAO marketing.

MA final rule- Updates for providers

1. MA plans will be required to follow traditional Medicare coverage guidelines when making medical necessity determinations. When coverage criteria are not fully defined by traditional Medicare statute, regulation, national coverage determination (NCD), or local coverage determination (LCD), MAOs may create publicly accessible internal coverage criteria. This coverage criteria must be based on current evidence in widely used treatment guidelines or clinical literature.
2. MA plans will be required to post internal coverage criteria publicly. Further, MA plans will need to provide a public summary of evidence considered during the development of the internal coverage criteria used to make medical necessity determinations.
3. MA plans must establish a Utilization Management Committee lead by the Medical Director, to annually review all utilization management policies including prior authorization. This review must ensure MAO policies are consistent with current coverage requirements, including traditional Medicare's national and local coverage decisions and guidelines. It is the MAO Utilization Review Committee's responsibility to ensure their policies remain current with changing requirements and regulations. These changes will help ensure MA beneficiaries have consistent access to medically necessary care, without unreasonable barriers or interruptions. This is qualitatively beneficial for enrollees and is not expected to have economic impact on the Medicare Trust fund.
4. Prior authorization policies for coordinated care plans may only be used to confirm the presence of diagnoses or other medical criteria, and/or ensure that an item or service is medically necessary.
5. Approval granted through prior authorization processes must be valid for as long as medically necessary to avoid disruptions in care, in accordance with applicable coverage criteria, the beneficiary's medical history, and the treating provider's recommendation. When a beneficiary currently undergoing an active course of treatment, enrolls in a new MA plan, the MAO will be required to provide coverage for a minimum 90-day transition period. This is not expected to have economic impact on the Medicare Trust Fund.

MA final rule- Changes for beneficiary protections and improved MA marketing

1. MAOs will be required to annually notify enrollees in writing, of the ability to opt-out of plan business contacts from their plan.
2. MA agents will be required to explain to the beneficiary, how their enrollment choice will impact their current coverage.
3. MAOs will need to clarify that the contact is unsolicited unless an appointment at the beneficiary's home was previously scheduled. MAOs will be prohibited from marketing benefits in a service area where those benefits are not available.
4. Use of the Medicare

Continued on page 18

Are med techs the answer?

by Bruce Glass, MBA, FACHCA

The staffing crisis we all face is not going away. To help address the issue, many states are letting specially trained nursing assistants pass medications. Currently, four New England states–Vermont, Maine, Rhode Island, and New Hampshire–are among the 31 states that allow this option. Each state has different rules, names, and ways to implement the practice, both for nursing homes and assisted living.

In general, each requires state-mandated training, special licensure and continuing education. States using med-techs (also known as medication nursing assistants and medical aides) report no increase in med errors, and general satisfaction with the positions.

The concept of med techs makes sense for many reasons. For example, the position offers a career ladder for nursing assistants. It also relieves nurses from a routine chore and helps deal with staff shortages. Ironically, those staff shortages have often led to some unique problems.

In Rhode Island, which has minimum staffing requirements, med techs and even nurses have been called upon to fill in for missing CNAs. Unfortunately, med-techs and misassigned nurses, do not count against minimum CNA staffing requirements–even though they likely upgrade the quality of care. In New Hampshire, where 65% to 70% of homes have closed units for lack of staffing, some facilities have filled nursing positions with agencies while using in-house nurses as LNAs.

Despite these problems, med techs fill a vital and economical role in patient care. Because of this, both Connecticut and Massachusetts, undeterred by repeated failures

Continued on last page

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Death with dignity

Continued from page 8

life choices and care. However, one barrier to use of medical aid in dying is the refusal of Medicaid to pay for the medications or professional services that are needed.

She reports that many assisted living and nursing facilities in Maine have policies that accommodate medical assistance in dying. Because assisted living residents often retain their own physicians, the facility need not take the lead on medical aid in dying.

Lovelace says that the best stance for a facility is neutrality. It is the role of the facility to support those staff actively assisting residents who pursue medical aid in dying as well as staff who do not wish to be involved. Increasingly Maine facilities have policies that guide them through these issues. With more than three years since passage of the enabling statute medical aid in dying has become more common and more accepted in Maine over time.

Death with Dignity Maine provides training for staff and others around these issues. Some of their trainings qualify professionals for continuing education units. The need for an original training at a facility is obvious but it is also a good idea to have refresher trainings for staff.

Valerie Lovelace feels that it is a good time for leaders of residential facilities to begin thinking about what statutes will mean for them in states that do not currently have enabling statutes. What problems will they encounter, how will they prepare staff, how will they counsel residents?

Demand is there, and medical aid in dying is likely to become a cultural norm at some point in the not-too-distant future. How many of our institutions and practitioners are ready to deal with it?

K.R. Kaffenberger is a former nursing home owner

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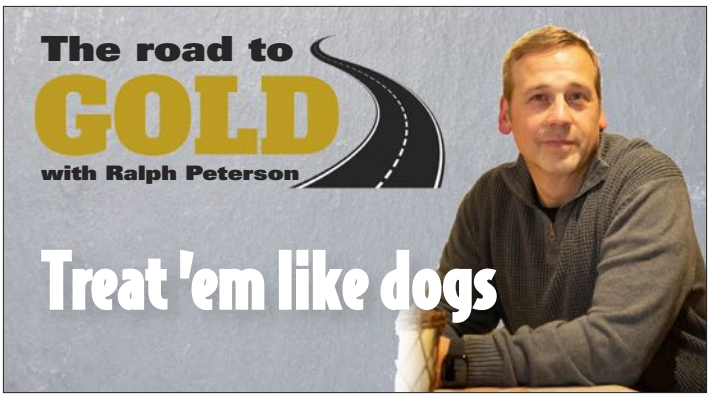


TOPSY WAS LAYING ON HIS FAVORITE PILLOW, sunbathing in the den, when the dog walker called out to him. He tilted his head at the sound but didn't move.

"There you are," the dog walker said, walking into the den. "Are you ready to go for a walk?"

Topsy's tail moved first, then he rolled over into a perfect down dog yoga pose and jumped off the couch.

They walked north on Walnut, turned left on Spruce, making a wide loop back to the house. Topsy was feeling good, had a little pep in his step, and mostly pulled the dog walker around the neighborhood. He "made" (our code word for number two) and happily enjoyed a couple of dog treats and some fresh water before the dog walker left.

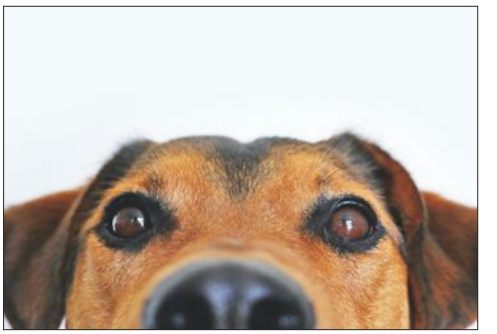
I know all of this because every day my dog walker sends me a text message describing her interactions with Topsy (my dog). Sometimes he eagerly goes on the walk, and other times he doesn't want to leave the front yard. Sometimes he "makes," and sometimes he doesn't. My favorite part is the fun picture she always includes.

When I first investigated getting a dog walker, I thought I knew what I wanted: someone to walk my dog when I couldn't. That's it.

I asked around, and a neighbor recommended her dog walker saying, she was the absolute best.

That's what she called her, "the absolute best."

"Okay," I said and smiled as she gave me her information. I wasn't sure what she meant by "the absolute best." I mean, if she showed up on time and let Topsy out to do



his business, I was good.

Then I got a text.

"Hey there. This is Natalie, the dog walker. I was excited to meet Topsy today," she wrote. "He is so sweet. He showed me around the neighborhood. He 'made' and I gave him two cookies and some fresh water before I left." Then she sent me a picture.

I sent the text and picture to my wife. She posted it on Facebook.

Soon, we both looked forward to that daily text and picture so much that we realized, our dog walker is not, in fact, in the dog walking business. She is in the dog owner business.

Anyone can walk a dog; however, it takes someone very special to realize the true

Continued on last page

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

Continued from page 4

9. GG0171C Lying to sitting on edge of bed
10. GG0171D Sit to stand
11. GG0171E Chair/bed-to-chair transfer
12. GG0171F Toilet transfer
13. GG0171G Walk 10 feet.
14. GG0171H Walk 50 feet with two turns
15. GG0171I Walk 150 feet
16. GG0171J Walking on uneven surfaces
17. GG0171K Negotiating stairs
18. GG0171L Wheelchair mobility

Section GG goals

Goals established should be based on the patient's/resident's functional status and his or her individual needs and preferences. These goals should be documented in the resident's care plan and used to guide the care provided by the health care provider.

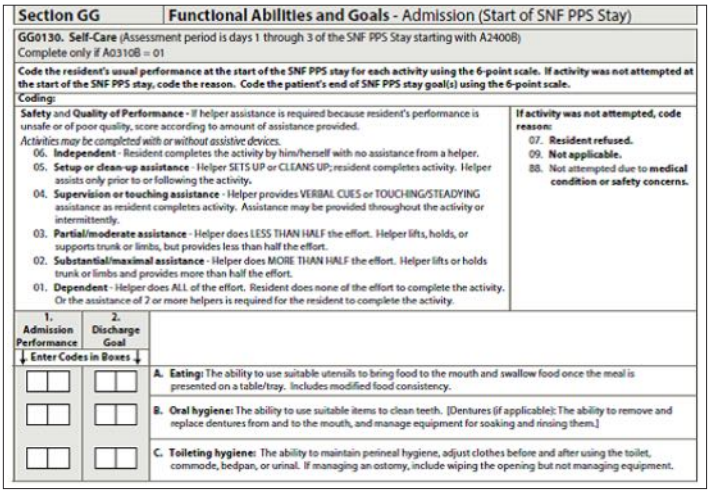
Section GG of the Minimum Data Set (MDS) is used in the assessment of Medicare and Medicaid beneficiaries in skilled nursing facilities. It is a standardized tool that measures the functional status and goals of the resident in various areas, including self-care, mobility, and communication.

Section GG involves identifying goals that the resident wants to achieve in the areas of self-care, mobility, and communication. The goals should be measurable and achievable within the timeframe of the resident's care plan. They should also be individualized and based on the resident's needs and preferences.

The goals identified in Section GG can be used to develop an individualized care plan that addresses the resident's needs and helps them to achieve their desired outcomes. The care plan should include specific interventions and strategies that will be used to help the resident reach their goals.

Top 19 things to know about Section GG

1. Section GG was created (via the CARE Tool) to monitor outcomes across the continuums of care (SNF, IRF, LTACH, HHA). It was spurred by the IMPACT Act in 2014. The IMPACT Act (improving Medicare post-acute care transformation) is a federal law that was enacted in 2014. Its purpose is to improve the quality of care and communication across post-acute care (PAC) settings, such as skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals. The IMPACT Act requires these PAC providers to report standardized assessment data, such as patient functional status, cognitive status, and medical conditions, to Medicare. The data is used to improve care coordination and patient outcomes across different PAC settings, and to inform payment policies for these providers. By requiring standardized assessment data across PAC settings, the IMPACT Act aims to facilitate better communication and care coordination among healthcare providers, ultimately leading to improved patient outcomes and reduced healthcare costs. It also aims to promote greater transparency in PAC quality measures, which can help patients and their families make more informed decisions about their care options.
2. The priority in creating Section GG was interrater reliability (meaning how accurate between two different coders), not accuracy of the coding system.



Section GG | **Functional Abilities and Goals** - Admission (Start of SNF PPS Stay)

GG0130. Self-Care (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B)
Complete only if A0310B = 01

Code the resident's usual performance at the start of the SNF PPS stay for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay, code the reason. Code the patient's end of SNF PPS stay goal(s) using the 6-point scale.

Coding:

Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:
07. **Resident refused.**
09. **Not applicable.**
88. Not attempted due to **medical condition or safety concerns.**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	A. **Eating:** The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.
☐☐	☐☐	B. **Oral hygiene:** The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.]
☐☐	☐☐	C. **Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan, or urinal. If managing an ostomy, include wiping the opening but not managing equipment.

3. Section GG Coding is significantly vague compared to how a therapist describes a level of assist.
4. The assessment reference date (ARD) on the Admission MDS Assessment has no impact on the assessment period for coding Section GG.
5. The timeframe for coding the admission Section GG is aways the first 3 days since admission and is unrelated to the ARD. See below excerpt which explicitly states that the Section GG Assessment period is days 1 through 3 of the SNF PPS Stay. Per the MDS' RAI Version 3.0 Manual CH 3: MDS Items [GG], October 2019 Page GG-13 (Page 277 of PDF):

GG0130: Self-Care (3-day assessment period) admission/interim/discharge (start/interim/end of Medicare Part A stay)

Assessment Period

- Admission: The 5-Day PPS assessment (A0310B = 01) is the first Medicare-required assessment to be completed when the resident is admitted for a SNF Part A stay.

"For the 5-Day PPS assessment, code the resident's functional status based on a clinical assessment of the resident's performance that occurs soon after the resident's admission. This functional assessment must be completed within the first three days (3 calendar days) of the Medicare Part A stay, starting with the date in A2400B, Start of Most Recent Medicare Stay, and the following two days, ending at 11:59 PM on day 3. The admission function scores are to reflect the resident's admission baseline status and are to be based on an assessment. The scores should reflect the patient's/resident's status prior to any benefit from interventions. The assessment should occur, when possible, prior to the resident benefitting from treatment interventions to determine the resident's true admission baseline status. Even if treatment started on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld to conduct the functional assessment.

- Interim Performance (Optional): The interim payment assessment (IPA) is an optional assessment

Continued next page

that may be completed by providers to report a change in the resident's PDPM classification.

"For Section GG on the IPA, providers will use the same 6-point scale and activity not attempted codes to complete the column "Interim Performance," which will capture the interim functional performance of the resident. The ARD for the IPA is determined by the provider, and the assessment period is the last 3 days (i.e., the ARD and the 2 calendar days prior). It is important to note that the IPA changes payment beginning on the ARD and continues until the end of the Medicare Part A stay or until another IPA is completed. The IPA does not affect the variable per diem schedule."

- Discharge: The Part A PPS Discharge assessment is required to be completed when the resident's Medicare Part A stay ends (as documented in A2400C, End of Most Recent Medicare Stay), either as a standalone assessment when the resident's Medicare Part A stay ends, but the resident remains in the facility; or may be combined with an OBRA discharge if the Medicare Part A stay ends on the day of, or one day before the resident's discharge date (A2000).

"Please see Chapter 2 and Section A of the RAI Manual for additional details regarding the Part A PPS Discharge assessment."

- o "For the Discharge assessment (i.e., standalone Part A PPS or combined OBRA/Part A PPS), code the resident's discharge functional status, based on a clinical assessment of the resident's performance that occurs as close to the time of the resident's discharge from Medicare Part A as possible. This functional assessment must be completed within the last three calendar days of the resident's Medicare Part A stay, which includes the day of discharge from Medicare Part A and the two days prior to the day of discharge from Medicare Part A."

6. Therapy coding terminology is far more sophisticated than Section GG coding terminology.
7. Section GG Coding cannot effectively portray a patient's/resident's function.
8. Section GG Coding is used in QRP quality qmeasures for SNF, IRF, LTACH, HHA settings.
9. Section GG Coding terminology should not be used in therapy coding terminology because it misrepresents the outcomes.
10. Section GG Coding terminology should not be used in therapy terminology because it understates the outcomes.
11. Section GG Coding terminology should not be used in therapy terminology because it optically dilutes the skilled therapy interventions rendered to the patient/resident.
12. Therapy should NOT be involved in any aspect of Section GG admission coding. If CMS expects therapy to participate in the coding of Section GG, this requires skilled services as therapy evaluations constitute skilled care.

Per the RAI manual:

"The admission functional assessment, should be conducted prior to the resident benefitting from treatment interventions to reflect the resident's true admission baseline functional status."

"If treatment has started, for example, on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld to conduct the functional assessment."

13. Section GG "raw data" can be extracted from many sections of the medical record. Because the terminology in Section GG is so vague, it is extremely easy to code Section GG from multiple sources. This is coming from an occupational therapist, whose entire career is based upon helping people perform daily activities, despite physical, mental, or emotional barriers. Data is obtained via reviewing the medical record, interviewing staff, and observing the resident.
14. Therapy Contractors must provide EHR access to LTPAC Providers and not restrict the right to use. Therapy contractors and employees (healthcare professionals) have a legal and ethical obligation to share clinical information with the interdisciplinary team members. If a healthcare professional were to restrict medical information without a legitimate reason, they could face legal consequences such as lawsuits or disciplinary action by their licensing board. In addition, patients/residents could potentially suffer harm if their medical information is not shared with healthcare providers who need it to provide appropriate care.
15. HHI recommends setting one goal for self-care and one goal for mobility. Each goal set must be care planned. (The facility does not need a goal for every item.) Currently, the QRP requires only one goal to meet the standard.

16. HHI recommends regularly reviewing and updating the resident's goals to ensure that they are still appropriate and relevant. By setting and working towards goals, residents can maintain or improve their functional status and quality of life.
17. Unlike skilled nursing facilities, IRFs are not required to document specific goals for Section GG.
18. IRFs are required to document a patient's expected discharge status and expected length of stay based on the patient's functional status at admission and progress during the IRF stay.
19. HHI strongly recommends removal of Section GG Coding from all therapy documentation and resume usage of therapy traditional coding i.e., the former method of describing functional levels.

In closing, HHI urges providers to review their current documentation composition in relation to Section GG coding protocols. By implementing the above recommendations, providers will improve accuracy of performance outcomes, perfect care planning and improve quality of care.

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.
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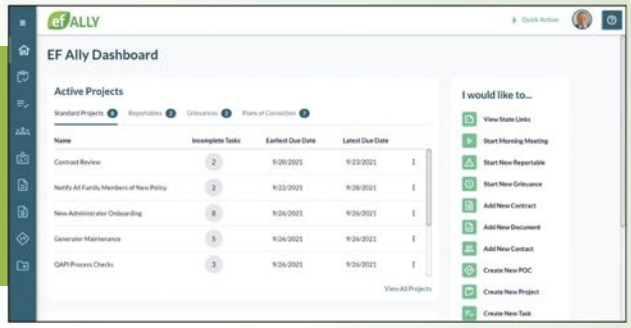

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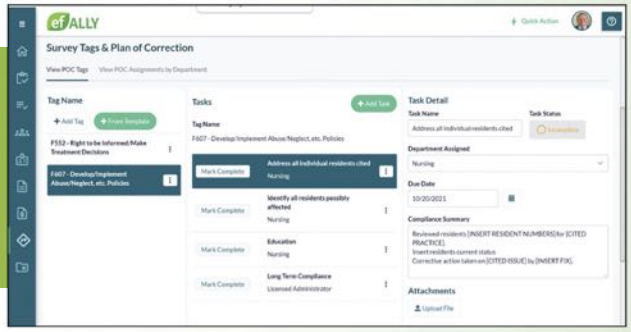

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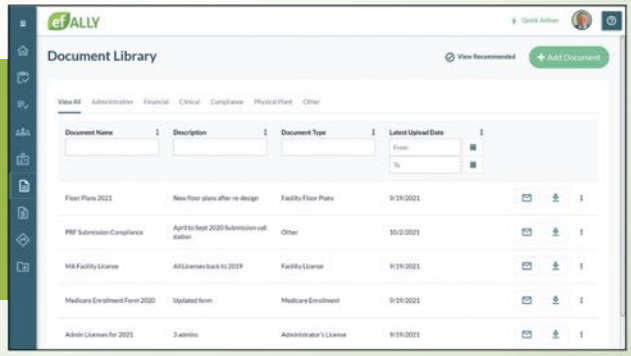

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The Marketing Guru: Those who need nursing homes are paying the price for closures

Continued from page 5

closures have disproportionately been in rural areas not urban areas. Does it make sense that the nursing home, which is the only center for 100 miles in any direction, must close, while six others operate in the nearest major metropolitan location?

Right-sizing assumes that the supply is elastic; that it can increase as well as decrease. This is not the case with nursing homes. With almost universal certificate of need requirements, and severe limits to capital formation in the sector, new nursing homes need more than four years to develop and become operational, assuming the developers can secure approvals, which often they cannot. An example of this extreme market intermediation are the struggles building nursing homes in the Green House model.

These "small house" designs had enormously better performance (lower infection rates, fewer deaths, and higher staff retention) than traditional nursing homes during the pandemic and are wildly more popular with residents, consumers, and staff. Yet they struggle to be built because of the intense intermediation of state and federal regulators.

Furthermore, we sometimes hear "Good riddance" from advocates who decry the situation in today's nursing homes. Residents being restrained with pharmaceuticals, horror stories of negligence – even abuse. These observations were the overwhelming substance of President Biden's reference to nursing homes in the State of the Union address a few years ago. Rhetorically, this is a popular move: Blame the nursing home. These are the same nursing homes strangled year after year by incrementally more regulations and draconian budgets. The US spends 54% of the OECD average on long-term care, and 243% on healthcare. Why?

Is this the right size?

What we're seeing now isn't "right sizing," but the chaos of supply contraction in a heavily regulated market where too few of the advocates really understand, and where none of the regulators have the political will to do more than make nursing homes scapegoats. What zealots cannot and will not address is what the replacement, or alternative might be. People who vaguely gesture toward home care and community-based services have clearly not recently been in a nursing home or tried to schedule a home health visit.

Staff

In any nursing home closure, direct care workers are also affected. Without a doubt, many of the direct care workforce are there because they derive great personal satisfaction from serving the old and vulnerable residents in nursing homes. News coverage of nursing home closures often places emphasis on the human side of the closure, featuring painful interviews with staff. Many of these caregivers do experience a profound personal loss.

For the sector, these workers should be cherished resources, and when they are absorbed into a job in an Amazon warehouse (which is likely with the employment rate so low), how can that compassion be replaced?

The sector has lost at least 240,000 direct care workers, perhaps more. These losses are quantifiable, but the personal empathy which so many brought to our oldest, most vulnerable people is truly immeasurable.

Who pays?

The losses of nursing homes and nursing home capacity have come at a time when demand is indeed at a nadir. Those born in 1935, the bottom point in the "demographic dip" are now 87. Over the next 3 to 5 years, we will see an increased demand for all types of aging services–including nursing homes–as the over-85 population starts to swell.

According to my back-of-the-envelope calculations, by 2030, there will be a deficit of over 400,000 congregate care beds in the US. Who will pay for the new, additional congregate care capacity that will soon be required? We are all paying now for the current closures through disruption, emotional distress, lost capacity and productivity. If we could prioritize the needs of three million Americans in congregate care, the total cost to society will be far less than the price being paid for ignoring them. And we might actually be proud of the result.

A profound realignment is needed today.

[1] Stackpole, I. Fatal Contraction. See: https://stackpoleassociates.com/long-term-care/fatal-contraction-healthcare-adjusts-to-a-shrinking-ltc-sector-free-webinar-december-1-2022/.

[2] Small Town Nursing Homes Closing. NBC News. See: https://www.nbcnews.com/health/aging/nursing-homes-small-towns-closing-staff-shortages-rcna66779

[3] Croot, E. The Financial Cost of Anxiety. Thrive Global. See: https://community.thriveglobal.com/the-financial-costs-of-anxiety/

[4] Work Years" is calculated as 1 Work Year = 2000 hours

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Changes to Medicare Advantage organizations

Continued from page 11

name, logo, and Medicare card image in MAO marketing materials will be limited.

5. MAOs will be prohibited from using superlatives in marketing materials unless the material provides documentation to support the statement.

Closing thoughts

Applauded by healthcare professionals nationwide, the MA final rule was acknowledged as a resounding "win" for providers challenged by MAOs for decades. The new CMS regulations will have a significant impact on providers and beneficiaries alike; making it easier for providers to accept beneficiaries waiting in the hospital for placement, providing clearer coverage guidelines for providers of all types, and entitling beneficiaries to a full episode of care without fear of interruption or termination of skilled services. Ultimately, providers should feel empowered to hold MAOs accountable to this new set of rules.

Have you received baseless denials from MA insurers? Partner with the experts at Celtic Consulting to fight managed care denials. Celtic is a post-acute care advisory firm, delivering operational, clinical, and financial support to health care providers. Our team of subject matter experts provide appeals and denials management assistance to clients nationwide. Further, Celtic Consulting specializes in managed care accounts receivable and revenue collections and has helped clients collect millions of dollars of outstanding revenue.

This article was originally published in the Marcum LLP "Trending in Healthcare" newsletter.

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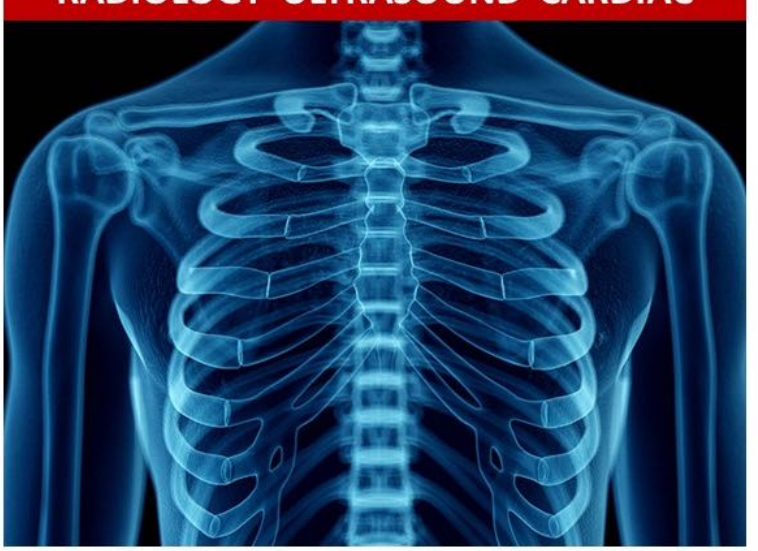

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Med techs fill a vital role in patient care

Continued from page 12

and powerful opposition from unions and nursing associations, are once again proposing legislation to legalize med techs in their states.

The bill in Connecticut, spearheaded by CAHCF, reads as follows:

"This legislation authorizes Connecticut nursing homes to employ Certified Nurses Aides (CNAs) with additional training and experience, as prescribed by the Department of Public Health, to administer medication to nursing home residents. This proposed authority is similar to the authority provided to homemaker home-health aides in the 2012 session of the Connecticut General Assembly. The specific certification requirements, including training and experience requirements, will be set forth in regulations promulgated by the Department of Public Health. Authorizing CNAs to administer medications in the closely supervised nursing home environment is a cost-effective approach to the safe administration of medicines. This proposal will establish a CNA career ladder noting that higher pay will accompany the higher level certification. Under the proposal a prescribing practitioner will have the clear authority to specify that a medication shall only be administered by a licensed nurse."

And in Massachusetts, both Mass. Senior Care and LeadingAge are urging the passage of the following bill:

"S.1468 would allow Certified Medication Aides to become part of the caregiving team after completing extensive training and competency testing and be allowed to dispense non-narcotic medications to residents. This position is allowed in over 30 other states and even in rest homes and group home in Massachusetts. With Certified Medication Aides conducting medication passes, nurses would have more time to complete resident assessments, provide vital nursing care and would be better able to facilitate hospital admissions. And this could happen quickly since both training programs and competency testing are readily available, including with the vendor that DPH uses for CNA certification."

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

The Road to Gold

Continued from page 14

value she brings to her customers, which is much more than dog walking.

"Don't worry. Your dog is doing great," her text says. "We had a fun time today. And look at this smile."

This got me thinking; what if, instead of only being in the "senior care" business, we were in the family member business as well?

What if, we started treating our residents like dogs?

"Hey there! This is Ralph, one of your mom's nurses at XYZ Nursing. We had a great day with mom today. She is doing great. Look at this smile <insert picture>!

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

Angela Perry elected as District One Director

Angela Perry, LNHA, FACHCA, ACHCA District One Director, is a skilled nursing facility administrator with over 15 years in the healthcare industry. She is also founder and CEO of CODE W (Connecting Opportunities with Determined and Empowered Women in healthcare). Her background includes operating skilled nursing facilities that provide long-term care and specialized units with focus on sub-acute rehabilitative services, memory care, and behavioral health in both Connecticut and Georgia. She is presently the administrator of a 150-bed facility in the Greater Hartford area.

Perry founded CODE W in 2017 to encourage women in healthcare administration to enhance professional development and pursue executive/ leadership and/or entrepreneurial roles within the healthcare industry to promote diversification. She coined the phrase, "Breaking the CODE," to magnify the importance of women to break through barriers and evolve within the workforce.

Among her leadership roles, Perry is presently co-chair for the ACHCA Diversity, Equity, & Inclusion Committee, a board of director member for the Connecticut Chapter of the ACHCA, and serves on the Member Experience Committee with ACHCA National. She has been featured in several national healthcare publications describing the environment of healthcare during the COVID-19 pandemic as well as various panels in the same regard.

Perry enjoys spending time with family, mentoring women in healthcare, attending symphonies and plays, and mountain running.

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