New England
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March
2020

"It is better to deserve honors and not have them than to have them and not deserve them."
-Mark Twain

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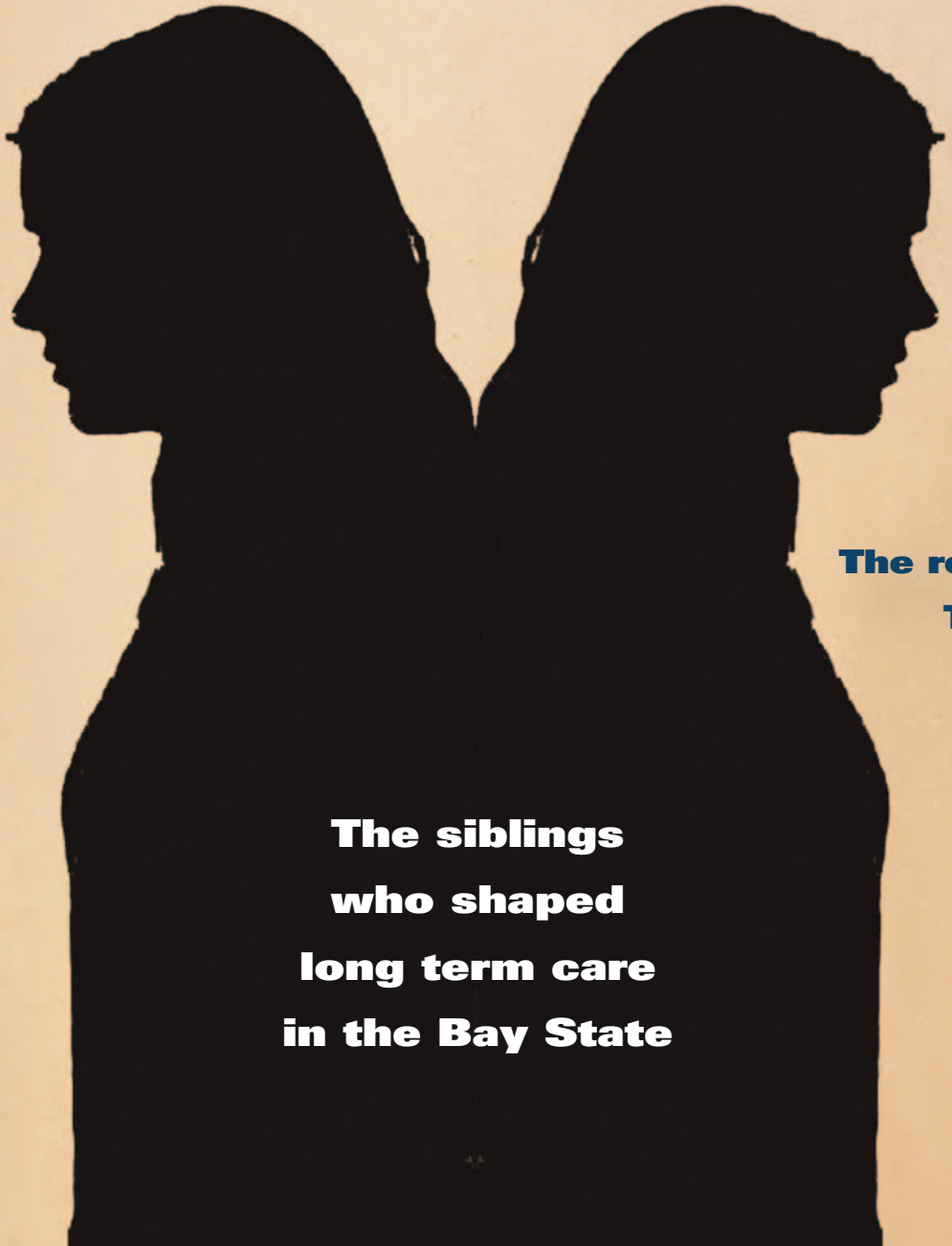

The siblings who shaped long term care in the Bay State

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Marketing futures

by Irving L. Stackpole, RRT, MEd

Welcome to 2020! You may think you escaped all of the New Year's retrospectives and prognostications, but since this is the first issue of this newsletter in 2020, my hope is that you will tolerate my marketing-based pontifications. (Complaints can be sent to Bruce Glass; compliments can be sent to me!)

Prognostications & Pontifications

After decades of reviewing the available data and conducting thousands upon thousands of interviews and surveys regarding supply and demand for seniors' housing, care and services, here are our observations:

- At the risk of stating the obvious, *demand* for congregate seniors housing and care in most places is reflected by the current *occupancy* in those same places. The demand in most marketplace areas is less than the available supply. The reason why occupancies are low is because the demand is lower than the available supply. Metropolitan areas with more robust economies like Boston, New York, Atlanta and others are the exceptions; most second- and third-tier cities and towns are struggling.
- Demand for skilled nursing facility (SNF) beds has been declining for decades and will continue to decline among the age- and disability-qualified population. This is a phenomenon across the United States and among almost all developed countries. A high number of SNFs are closing due to inadequate demand and/or bankruptcy. This will continue into 2020 and beyond.
- The age-qualified population for seniors' congregate housing and services is not those over 60, 65 or 70 years of age, as is often reported in the press. The average age of relocation to an assisted living residence in the US is 86.4 years of age. That's the average! And the average age of admission to a nursing home (SNF), adjusting for short-term rehab, is over 87 years of age. This trend will also continue, with average age of relocation creeping up toward 90.
- The total demand for congregate seniors housing plus SNF beds will continue to decline further until 2030 when the leading edge of the Baby Boom generation turns 85.
- The bright spot is home care. Various permutations and combinations of domiciliary care, support, and technology will proliferate over the next 10 years. The home care supply model will undergo significant changes, driven by the requirement for greater efficiency and the application of current and yet-to-be configured technologies. Think "telehealth on steroids."
- In a declining market, with increasing wage pressure, providers & suppliers have only a few choices, and one of them is to become more efficient. "Efficiency" will become the new buzzword, and everything from time-saving devices to flexible staffing models will emerge. By time-saving devices, I am not referring to so-called kiosks parked in the middle of nursing stations or residential wings, but technology that's transparent, portable, and passive.
- The future demand for SNF beds, after 2030 in particular, will be driven by the epidemiology of Alzheimer's and related disorders (ARD) and neuromuscular diseases. The prevalence (how many have these diseases) and incidence (the rate at which these diseases appear in the population) are well understood and driven by the demographics of ageing. Also, any estimate or prediction of SNF demand must account for imminent pharmacological and genomic breakthroughs in the treatment of ARD.
- The future of seniors' housing and care is not the institutional model developed in the 1950s and 60s with which most of us are familiar, but rather looks more like what is occurring in Japan. Social systems and service provision will be adapted to meet the elderly where they

Continued on page 12


Irving L. Stackpole

Trauma-informed care in a skilled nursing facility

by Kris Mastrangelo, OTR/L, MBA, LNHA

For Skilled Nursing Facilities and other healthcare organizations to provide trauma-informed care, the first step is to understand the definition of trauma: a deeply distressing or disturbing experience such as a personal trauma like the death of a child; emotional shock following a stressful event or a physical injury, which may be associated with physical shock and sometimes leads to long-term neurosis; physical injury.

Examples of trauma

Survivors of:

- Holocaust
- War
- Physical Abuse
- Mental Abuse
- Emotional Abuse
- Domestic Violence
- 911
- Rape
- Mass Shootings
- Kidnapping

Per "Psychology Today," trauma is the experience of severe psychological distress following any terrible or life-threatening event. Sufferers may develop emotional disturbances such as extreme:

- anxiety
- anger
- sadness
- survivor's guilt
- PTSD
- ongoing problems with sleep or
- physical pain
- encounter turbulence in their personal and professional relationships,
- feel a diminished sense of self-worth due to the overwhelming amount of stress

Kris Mastrangelo

Despite the devastating effects of trauma, it is possible to develop healthy ways of coping with the experience and diminishing its effects.

Coping mechanisms

According to CMS and research, healthy ways of coping, such as:

- avoiding alcohol and drugs
- seeing loved ones regularly
- exercising
- sleeping
- paying attention to self-care

In addition, culturally competent and trauma-informed care are approaches that help to minimize triggers and re-traumatization.

Traumatic experiences often arouse strong, disturbing feelings that may or may not abate on their own. In the immediate aftermath of a traumatic event, it is common to experience shock or denial. A person may undergo a range of emotional reactions, such as fear, anger, guilt, and shame. Feelings of helplessness and vulnerability are also common. Some may experience flashbacks and other signs of PTSD. Traumatic memories fade naturally with time. Persistence of symptoms is a signal that professional help is needed.

Trauma-informed care understands and considers the pervasive nature of trauma and promotes environments of healing and recovery rather than practices and services that may inadvertently re-traumatize. Traumatic events have an adverse impact on physical and emotional health and effect the way in which people respond. Trauma places a significant burden on those affected, their families and support systems.

Additional effects of trauma

- Stress reactions
- Impaired neurodevelopmental response
- Impaired immune system response
- Health risk behaviors
- Mental and substance use issues
- Chronic physical diseases

Paths to recovery

Regardless of the original cause of trauma, survivors have demonstrated paths to recovery. Trauma-Informed Care is a strategy to focus on the impact of trauma and how service systems and caregivers can either resolve or intensify trauma-related issues. These needs are an important aspect of person-centered care.

SAMHSA framework

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as psychically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

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ROGUES & PIONEERS

Two Sisters

by W. Bruce Glass, FACHCA, CNHA, CALA and Julian Rich, FACHCA, CNHA

The early history of senior care was directed largely by family-owned organizations. Some provided outstanding care, while a few led to the scandals that besmirched the reputation of nursing homes.

The tale of sisters Florence (Edna) Logan and Rita Welch begins as inspirational, but, at least in one case, ends differently. Herein is the tale of two sisters who were pioneers in the early days of our industry, blazing impressive trails as they developed nursing homes in Massachusetts. The ultimate legacy led to an enduring multi-generational success for the Welch family but, unfortunately, less so for the Logans. Read on.

Rita (St. John) Welch 1921-2014

Rita Welch's story is truly one for the ages.

However, the beginning parallels that of many others in the early years following World War II.

In a tradition of caring received from her R.N. mother, Rita and her husband Frank bought a large house in Braintree, MA, and began to take in a few elderly boarders.

At this time there was no reimbursement other than Social Security, and even fewer regulations. It was truly a "mom and pop" industry, and the Welches were there at the outset.

With little precedent to guide them, the Welches gradually expanded their small business by eventually converting the entire first floor to caring for their "guests." Frank continued to work at his full-time job while putting his carpentry skills to work making the place more livable. Rita took charge of the care and the business aspects.

Continued on next page

Rita Welch, from a 2009 article in "The Patriot Ledger."

Continued from preceding page

In a few years they converted the entire John Scott House to long term care, and continued to expand it until it took on its current configuration.

At the same time, the industry as we know it was also taking shape. Rita began meeting with other owners, and collectively began to set standards of care, in conjunction with the Massachusetts Department of Health. This soon led to the formation of the Massachusetts Federation of Nursing Homes (now the MA Senior Care Assn.), of which Rita was one of the first and most active presidents.

She also expanded her outreach to state officials over issues of regulation and reimbursement. Her professionalism was soon recognized, and Governor John A. Volpe appointed her chair of the commission that developed the first licensure rules for nursing home administrators in the country. In recognition, she was awarded license number one.

Rita was also chosen secretary of the newly-formed American Nursing Home Association (now the American Health Care Association), and was one of the first presidents of the Massachusetts Chapter of the American College of Nursing Home Administrators (now the American College of Healthcare Administrators).

Remarkably, while developing a successful business, she still found time to raise a family of seven children. Like the business, the family expanded, so that at the time of her death in 2014, it consisted of 25 grandchildren and 42 great-grandchildren.

Welch Healthcare continued to grow under her leadership, and many of the standards she set became ensconced in regulations. Not content with a single entity, Colonial, one of the first truly modern nursing homes, was followed by several others on the South Shore of Massachusetts. Without exception, they became recognized by regulators, families, and communities for their quality of care and compassion for residents. As the company grew, Rita continued to provide industry leadership within the Commonwealth and across the nation.

For her work, Rita was awarded an honorary Doctor of Humane Letters from Stonehill College, and her NHA License #1 was permanently retired. In 1975 Rita handed control of Welch Healthcare to the next generation of the family.

In the tradition of family-owned organizations, many members were involved. Chief among them were sons Richard and Michael, daughter Marianne Martinez, and son-in-law Paul Casale. Under their leadership the organization continued to grow and prosper. Early on, the facilities provided childcare for staff, along with numerous educational programs.

The organization quickly realized that diversification and expansion were the keys to long-term survival and added, in addition to four nursing homes, consulting services, assisted and independent living, and a continuing care retirement center.. They also partnered with other family operations to form the Aurum Network, a unique consortium which fostered improved services and economies of scale to better compete with chain corporations. At its peak, Welch Healthcare and Retirement Group cared for more than 3500 individuals.

In 2016 the nursing homes were sold to BaneCare, another family group noted for similarly high standards. The Welch family continues to operate the remaining entities, with yet another generation now involved with the business.

Florence Edna (St. John) Logan, 1917-2011

In many respects, the life of Florence Edna Logan paralleled Rita, her younger sister.

She was the founder of Elihu White Nursing Home in Braintree and Logan Park Senior Housing, and her family legacy included five facilities located south of Boston and Rosewood Nursing and Rehabilitation Center in Peabody, one of the most unique buildings of its kind in New England. When Rosewood opened in 1996, the Logan family, under the matriarchal direction of Edna, was intimately involved in the organization, and she contributed to the success of all of the facilities. Edna was proud to mentor and include all of her children at one time or another in the organization, and after her retirement, her sons took over the business and were able to expand beyond the South Shore and into Peabody, located about 20 miles north of Boston.

Edna was a charter member and fellow of the Massachusetts chapter of the American College of Healthcare Administrators and also was a member of what is now known as Massachusetts Senior Care Association (formerly, the "Federation") for 40 years. She was also active in a variety of South Shore organizations and served on the board of directors of two South Shore banks and was a longtime member and supporter of the South Shore Chamber of Commerce. She was an active Rotarian and was awarded the prestigious Paul Harris Fellowship award from the Rotary club of Braintree. One of her favorite charities, the Friends of the Thayer Public Library can attribute its success to Edna as she was the chair of a fundraising campaign that collected over three-quarters of a million dollars for a new building.

Unfortunately, although the facilities grew and evolved throughout Edna's lifetime, they were taken over by other nursing home organizations after a series of issues that led to the demise of the Logan nursing home chain. The increased complexities of managing healthcare facilities in general and nursing homes in particular and changes in regulations, aside from issues that sometimes occur in family businesses, all contributed to the aforementioned changes for the Logan family holdings.

In addition to Rosewood and Elihu White, the family's holdings at one time also included Pond Meadow Healthcare Facility in Weymouth, Logan Nurs-

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The rewards are worth every bit of the work

by Matthew Lessard, FACHCA, CNHA

As a 16-year veteran administrator I feel that I am at the top of my game. I've gained the experience necessary to handle most any situation our industry can throw at me. I'm well connected with other administrators within and outside my corporation, throughout Maine, across New England, and even across the United States thanks to the American College of Health Care Administrators. I'm at the midway point of my career, no longer a "new administrator," but too young to quite be considered "distinguished."

Following a great deal of contemplation and consideration, I am choosing to share a very low point in my career; call it a mid-life crisis, an internal conflict of man versus himself, or just me not handling life appropriately. I share this experience in hopes others in their mid-careers or experiencing an extremely difficult time in life will know that they are not alone in their experience and that what we do every day is much more than a job. It's a career and a way of life.

Every two weeks my facility holds a new employee/annual orientation day. I begin this daylong training at 7 a.m. with a profound thank you to the staff who are present for either their years of commitment or their choice to work in the challenging field of post-acute care and most importantly, at our specific center. The work is hard, harder than most other jobs, and pay and recognition are often lacking. After 15 years of repeating this practice at every orientation training, and reflecting on each day's work–having run several post-acute operations of varying sizes–I started down a slippery slope. I thought about how today we are working to solve the very same problems we were trying to solve 15 years ago: staffing, callouts, employee morale, finding a new niche market, getting through

survey, taking the best possible care of our residents and patients. Essentially, it's the same job as it was when I entered the profession in 2003.

Why was I getting up early every day, working long hours and weekends, and getting called at home, when I could be earning more and working less in acute care–or even better, in another field altogether? The problem was, after 15 years of dealing with the same issues and doing the same thing, I had become almost too specialized.

In late 2017 my organization asked me to take over our largest skilled operation, the third largest nursing facility in Maine, and the busiest skilled center. Cautiously, I agreed and began the long road of creating and implementing systems in a large, very busy, and highly resistant building. The mentality of the facility was that rules and corporate initiatives did not apply to them because they were different. Meanwhile, the building continued to lose money each month, family and resident complaints abounded, and I actually considered creating office space for DHHS because they visited so often.

Then my world actually came crashing down. In May of 2018, after being in remission for four years, my wife was re-diagnosed with leukemia.

We spent the following four months in Boston; she had two month-long continuous stays, and I traveled back and forth, working three days per week and spending the rest of the time in the hospital with her. In between her two long stays there were weekly trips to her oncologist in Boston. Each trip took an entire day. After her second month-long hospitalization for a stem cell transplant, there were weekly trips back to Boston to monitor her progress. To say the least, I was not able to put the time and effort into my work that had been needed. Survey had occurred the first week she was diagnosed, so I wasn't able to be present and support the staff. The plan of correction largely happened without me. As a seasoned administrator who normally has his finger on the pulse and manages operations in a controlled fashion, this did not work for me.

Over that four- to five-month period, during the times that I was at work, my personal life really affected who I was and how I behaved. We tell our staff over and over that they

Continued on next page

Two sisters, two SNF empires

Continued from page 6

ing and Rehabilitation Center in Braintree, the Atrium Nursing and Rehabilitation Center in Middleborough, and Crestview Healthcare Facility in Quincy. However by 2008, all of their facilities had been either sold or closed due to legal problems, regulatory issues, and changes in federal and state reimbursement, all of which negatively impacted their revenue streams. Clearly Edna was proud that she could not only provide for frail elders but also for the many members of the Logan family that worked for the organization. The generous payroll and decreased income also contributed to the demise of the Logan family senior care organization.

Thus, the two sisters were clearly part of the strong foundation established in the early stages of nursing home operations in Massachusetts, but went in different directions as regulatory changes and legal issues were difficult to overcome. Clearly, they helped to establish standards for owners and operators that have and will continue to impact the lives of frail and needy seniors.

Edna Logan

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Julian Rich, FACHCA, CNHA, is a long-term member of ACHCA and has been active since 1978. He is the founder of J RICH SOLUTIONS and continues to be involved in the field as a consultant, interim executive, and expert witness. He can be reached at 508-361-4799 or Juliangrich@gmail.com

Yes, you really make a difference

Continued from preceding page

need to leave their personal life at the door and not bring it to work. That is, by far, easier said than done. All those held-in emotions and experiences came out in my interactions with staff, my responses to people, decisions I made, and how I lead the team. For the most part, I was ineffective and it was not without effect on the team, the staff, and the facility. During my annual review meeting with my boss, I remember saying to her, "I really just don't want to be an administrator anymore."

I'm not sure if it was saying those words out loud, or the realization that I didn't know what I wanted to be when I grow up. It could have been my anxiety around how my skill set would apply to other workplaces or industries. Whatever it was, the following month I decided that I was going to commit fully and move forward as the administrator of my current facility and make it the flagship I was asked to make it in the first place.

Once I committed, things started to turn. After a few hiccups, mostly related to my previous behavior and lack of leadership, the leadership team grew together. We hired a new director of nursing, one that I had worked with previously and I knew would match my drive for what the facility could become. For a little over a year we have worked to build up the team we envisioned, implement systems in numerous areas, and create a caring culture for both residents and staff. 2019 ended with a positive bottom line for the first time in over 5 years. When CMS updated its star rating report, I was proud to note that the facility had moved to 5 stars, surpassing our local competitors and becoming the only 5-star facility in our city.

I write this article because I believe it might resonate with other administrators who look in the mirror and wonder if there is something else they should be doing with their lives. Are you at that point where you wonder if working in post-acute care and in our profession, arguably one of the most challenging careers, is worth the time and effort? Does it really make a difference?

If so, I say life is full of ups and downs and you are just as human as the patients and residents for whom we provide care. Through these ups and downs I have realized this profession is well worth the strife. The rewards are worth every bit of the work. We sometimes have to look deep into our worlds to find that spark of inspiration and satisfaction, but when we look deep enough, it's there.

My wife has fortunately returned to good health–battling the aftereffects of her treatment have become a part of our daily lives. I'm proud of where I work and of the work I choose to do every day. Like so many things in life, you get out of it everything that you put into it. Hopefully in the next chapter of my life I'll use all those management and leadership skills honed over the past 16 years to raise a brood of adopted children.

Matthew Lessard, FACHCA, CNHA is District Director, ACHCA Region One and Senior Administrator with First Atlantic Healthcare in Portland, Maine.

ACHCA New England MEMBERSHIP

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HIPPA & technology

by Phil Cardone

WE'VE ALL HEARD ABOUT HIPAA COMPLIANCE AND WHAT WE NEED TO DO TO ENSURE OUR USE OF TECHNOLOGY MEETS CURRENT REGULATIONS.

But with a healthcare industry that's continually evolving, this means that rules and regulations are as well. With these constant changes, every healthcare-related organization must have a game plan in place to remain compliant. Here are five ways to create, adjust and implement a HIPAA compliance plan.

1. Designate a privacy and security officer

This can be your IT managed services provider (MSP) or an employee who ensures that your company remains compliant. This is a foundational building block for your compliance success. Hiring an individual or managed IT provider who has a track record of success is critical for HIPAA compliance.

Phil Cardone

2. Perform a risk assessment

This is an overall review of both macro and micro levels to ensure your electronic protected health information (ePHI) is secure. This is a mandatory aspect of any healthcare organization's compliance endeavors. Not only is it compulsory, but also it's the foundation for implementing safeguards to better protect your organization.

3. Implement Policies and Procedures

You must provide your employees and anyone who handles your sensitive information a blueprint explaining the dos and don'ts when it comes to HIPAA compliance. Your blueprint must continuously be updated and adjusted as you implement your compliance planning. For example, encryption is necessary to protect electronic protected health information (ePHI). This is an extra layer of security, comparable to an unbreakable password. Other standard procedures like locking a laptop when it's not in use should be included in your policies and procedures. There are other examples where policies and procedures will help ensure HIPAA compliance.

4. Train your employees

Security awareness training for your employees should be implemented to ensure everyone in the organization understands your policies and procedures. The best plan in the world can be ruined by employees who don't understand what they can or cannot and should or should not do. Take the time to train them on best practices for handling sensitive information and what constitutes a HIPAA violation. This is also a mandatory aspect of HIPAA compliance.

5. Develop and implement an incident response plan

What if you've done everything that you should? Everything is in place; you've "checked all the boxes" but you still experience a breach? Report it! Have a plan in place to identify and respond to a threat. Once the source is determined, stopped, and documented, it must be reported. From this point on, you should have a prevention plan in place to ensure a breach doesn't occur again.

Train your employees about IT security best practices.

What should you take from this?

Healthcare organizations are exposed to daily dangers and threats to their HIPAA compliance status. With the right plan in place, you have a chance to protect your business from security threats and violations.

Create a HIPAA compliance plan, and most importantly, train your employees about IT security best practices. Remember to always report incidents and regularly evaluate your organization's HIPAA compliance regulations and practices to consistently improve your IT security posture.

Phil Cardone is an Information Technology Specialist with 15 years of experience in outsourced IT consulting and 2 years as a Health Care IT Director. Broad portfolio of duties performed as Director of IT, Senior Technical Engineer, Purchasing and Procurement Manager, Sales Executive, Project Manager and Client Account Manager. Dedicated client advocate and motivated team leader always challenging processes of today to adapt to technologies and solutions of tomorrow.

Upcoming Events

ACHCA Massachusetts Chapter
Annual Meeting
Wednesday, April 1, 2020
Gillette Stadium in Foxborough, MA

ACHCA Connecticut Chapter
Annual Meeting
Wednesday, April 22, 2020
Zandri's Stillwood Inn in Wallingford, CT

New England Alliance
Spring Regional Conference
May 20 to 22, 2020
Newport Harbor Hotel & Marina, RI

The C.A.R.E. Expert on trauma-informed care at SNFs

Continued from page 4

Responses to trauma

May manifest in behaviors or conditions that result in:

- involvement with the criminal justice system,
- difficulties with education,
- loss of employment, or
- overuse of the healthcare system
- behavioral health disturbances
- substance use issues

4Rs of trauma-informed approach for staff

1. **Realize**– Understand the impact trauma can have on families, groups, organizations, and communities. Seek to understand the individual's experience and behavior in the context of how the behavior may be a coping strategy.
2. **Recognize**– Recognize the signs of trauma.
3. **Respond**– Respond in a way that allows creation of an environment that is safe and supportive, rather than stressful and toxic.
4. **Resist re-traumatization**– Prevent re-traumatizing via:
   - Having to continually retell their story
   - Being treated as a number
   - Procedures that require disrobing
   - Perceived as "labeled"; addict, schizophrenic, etc.
   - No choice in service or treatment
   - No opportunity to give feedback about their experience with the service delivery
   - Not being seen/heard
   - Violating trust
   - Failure to ensure emotional safety
   - Use of punitive treatment, coercive practices and oppressive language

6 principles of trauma-informed care for staff

1. **Safety**– The resident must feel safe with those providing the care to them at the facility. Both the physical setting and the interpersonal interactions must convey a sense of safety.
2. **Trustworthiness and transparency**– Be sure the resident feels the organization and infrastructure is trustworthy. This starts at the top. Administrator and DON need to connect with resident.
3. **Peer support**– Provide a peer support group to patients/residents on a regular basis.
4. **Collaboration and mutuality**– Since trauma often involves misuse of the power gradient, a shared decision-making environment prevents re-traumatization.
5. **Empowerment, voice and choice**– Survivors require control of their situation. Identify scenarios that trigger the resident and problem solve solutions to mitigate exacerbation of emotional disturbances. Provide the resident with options and the ability to make decisions.
6. **Cultural, historical and gender issues**– Be mindful and sensitive to gender, cultural and historical implications and ensure the environment and approach are in alignment at a resident specific level of detail. This includes the care plan.

Health inspection survey implications

The Requirements of Participation expect all SNFs to properly render trauma-informed care. F-Tags associated with noncompliance include

- 483.21 Comprehensive Person-Centered Care Planning
- 483.21(b)(3)(iii) Trauma informed care – implemented in Phase 3 (November 28, 2019)

Services provided must be culturally competent and trauma informed.

- 483.25(m) Trauma-Informed Care

The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.

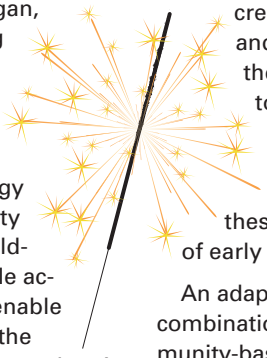
The concept of trauma-informed care is new to the long-term industry. Compliance requires ongoing staff training and refined policies and procedures on all aspects of trauma informed care. Harmony Healthcare International (HHI) is always available to help you on this endeavor.

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*

Prognostications and pontifications

Continued from page 3

really are. In many ways this is a true counterpoint to ageism; not a slogan, not an advertising campaign by the senior center, but the deployment of enabling services and technology into the community itself, where the elderly and vulnerable actually live. It will enable them to reside in the community far longer than is currently accepted or tolerated.



- Mergers and acquisitions in the sector will continue in 2020, although we expect them to decline in both volume and value by the end of the year, and certainly by the second quarter of 2021. As prospective buyers become more sophisticated regarding which assets in a portfolio are performing well and which aren't, valuation adjustments will have downward pressure on average unit prices. In this scenario, the "status quo bias" may be more powerful, resulting in fewer transactions.
- The "Golden Girls" model will eclipse "Fawlty Towers." Friends and acquaintances will move in together and create social networks and navigate acquiring the services they need together. Smart providers have already positioned themselves into these networks as a way of early brand development.

An adaptable and flexible combination of home and community-based services, technology and social awareness are needed to "future proof" ageing societies. I would welcome the opportunity to discuss, defend or expand on any of the above! I look forward to hearing from you.

 Irving Stackpole is President of Stackpole & Associates, a marketing, research & training firm. Contact Irving: 617-739-5900, ext. 11 istackpole@stackpoleassociates.com. StackpoleAssociates.com

Rethink hospice services at your facility

by Roxie A. Severance, CNHA, FACHCA

I'm sure we all agree that our skilled nursing facilities (SNFs) are more than qualified to care for residents in their final days. This thought leads to many SNFs deciding not to utilize the resident's Medicare Hospice benefit. With the severe staffing crisis we are experiencing, I think the savvy SNF administrator needs to rethink working with their local hospice agency.

A hospice agency can bring added value to your resident, your staff, and facility. Recently, a hospice agency reported to me that they were able to provide a nurse aide 40 hours a week to a SNF facility for the hospice patients on services. The hospice nurse aide was able to assist with bathing, dressing, feeding and answer call bells for those hospice patients. In this case, facility LNAs appreciated the extra hands available to help. Most hospice agencies have trained volunteers to sit vigil with residents so facility staff members do not have to feel guilty leaving them alone to care for other residents. Some hospice agencies provide pet therapy and help with last wishes as well.

In a nursing home setting, a hospice agency can help patients, families, and nursing home staff by providing regular visits from a hospice RN, consultations by a specialized hospice physician, assistance in the management of pain, education for nursing staff, patients and families, emotional and spiritual support for patients and families, medication and supplies that relate to patients' terminal illnesses, and coordination of patient care and medications across all medical providers. The SNF is responsible for communicating and coordinating patient care with hospice; monitoring patient condition and reporting changes to hospice; routine daily care; normally scheduled medical care and examinations by the attending physician and medical director; and providing medications and supplies for care not related to the patient's terminal illness. The SNF needs to keep in mind that hospice benefits do not usually cover the daily room and board costs–those costs are generally covered if the patient is on Medicaid or has the ability to pay privately.

During my tenure as a nursing home administrator, our facility worked with two local hospice agencies. We had varying degrees of success. Some of the issues included documentation, staff not understanding how the program worked in a nursing home, and resistance to having someone else care for "my patient." Issues such as these could easily be solved by having the hospice agency provide education to nursing staff.

The benefits of working with local hospice agencies are great, particularly if you take the time to learn how the program can work in your facility. A positive relationship with your local hospice agency would help you provide extra care for residents in their final days and their families. Utilizing hospice would not solve your workforce shortages, but I believe it has the ability to assist in alleviating some of the stress your facility caregivers may be experiencing. The key to a positive experience is open communication between your staff and the hospice staff and making sure everyone knows they are on the same team.

Contact your local hospice provider to learn more about how they can provide support to your hospice residents and staff. A listing of Medicare Hospice providers and their star rating can be found at medicare.gov/hospicecompare/. For more information about Medicare hospice: medicare.gov/pubs/pdf/02154-medicare-hospice-benefits.pdf.

Roxie Severance is the president of RS Consulting, LLC in Whitefield NH; she is a consultant with the New Hampshire Health Care Association working on their Music & Memory and Workforce grants/contracts. She is board chair of North Country Home Health and Hospice Agency

Eli Pick Facility Leadership Award

The Eli Pick Facility Leadership Award (EPFLA) was introduced in 2008 by one of ACHCA's most revered leaders, the late Eli Pick. A former executive director of the Ballard Rehabilitation Center, DesPlaines, IL for over 30 years, Eli embodied excellence as an administrator that cared for his residents, their families, and his community.

Eli worked with his colleague, John Sheridan of eHealth Data Solutions, to develop an awards program that uses data-driven criteria to objectively identify high-performing skilled nursing facilities (SNF) and the leaders who make them excel.

EPFLA recipients are identified using publicly collected data from the Centers for Medicare & Medicaid Services (CMS) QM and Survey Data, which is pulled and evaluated by an independent third party. The rankings are pulled based on 2018 data. Administrators of those high-performing SNFs are celebrated and honored during ACHCA's awards ceremony held at the Annual Convocation and Exposition.

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