New England
ADMINISTRATOR

June
2019

"Nothing so needs reforming as other people's habits."
-Mark Twain

District One
ACHCA
American College of Health Care Administrators

Bored to Death in a Five-Star Nursing Facility: A True Story

by Edison Beaumont

My family turned to me, naturally, to find a facility for our mother when she needed 24-hour care.

After all, I had been working in skilled nursing/long term care for my entire career. My first consideration was proximity for my father to visit daily, which meant I would not be moving mom out-of-state to where I worked. Second, Mom's doctor had admitting privileges in five local nursing homes, so I drilled down on each one, using available data at Medicare.gov, to research their staffing levels, deficiencies, etc. Only one of the five was rated as five stars. It was also Joint Commission-accredited, and a reputable company with which I was familiar operated it. Its website boasted of "person-centered care" among other things. I patted myself on the back and assured my family that Mom would be in good hands.

The first time I visited was at 9 a.m. on a Saturday. She was sitting up in bed, asleep, slumped over to one side, with her breakfast tray in front of her. She had taken a few bites of toast, but that was all. I woke her up.

"I'm so tired," she said. "They woke me at 5."

"Why?" I asked.

"Because that's when things start around here. They turned on the overhead light and said 'Mary, time for your medicine.'"

"That's exactly how they did it," her roommate chimed in.

I left a message for the director of nursing to call me. On Monday afternoon, she did.

"Your mother needs to take her meds on an empty stomach," she explained, "and breakfast is at 7:30."

"So you have to work around the kitchen's schedule?"

"We have 122 other people to provide care to, and we only have so many staff," she said.

So much for person-centered care, I thought.

On another visit, my mother was not in her room. She was in the lineup across from the nurse's desk in the center hallway. I didn't

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Evacuate!

by Bruce Glass

The call came at 9:38 AM on January 21 to CEO Mary Beth Daigneault of St. Clare Newport. Every administrator's worst nightmare.

Somewhere in the National Grid gas network a signal indicated a dangerous decrease in pressure. Following a disastrous explosion in Lawrence, MA, no one was taking any chances.

Homes and businesses were faced with an unprecedented crisis as all gas services were interrupted for an indefinite period for nearly 7,000 gas customers. Businesses were closed. Occupants of hundreds of homes in Newport were forced to seek temporary shelter. It was a daunting scenario.

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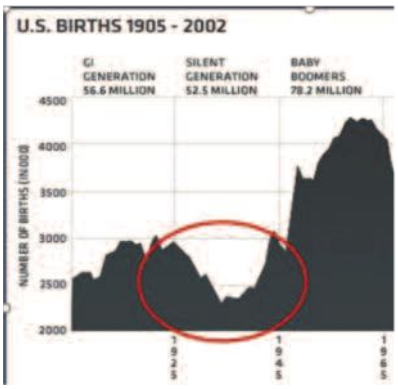
THE MARKETING GURU

Waiting for the wave: Demand for long-term care

by Irving L. Stackpole, RRT, MEd

A RECENT ARTICLE IN *MCKNIGHT'S LONG-TERM CARE NEWS*, "DON'T BANK ON TSUNAMI" suggests that "Potential residents will be plentiful…" and the article cites several experts who report that the demand for senior housing will increase.

In order to "catch a wave" you need to know when the peak demand for age-related long-term care services will arrive. One person quoted in the McKnight's article suggests that "…demand for senior housing and healthcare anticipated to spike around 2025." This prediction is at least five years too soon.



In 2025, those who are 85 will have been born in 1940 (See the chart of births). In 1940, the birthrate was only beginning to recover from the Great Depression and Dust Bowl phenomena, and it isn't until 1944 that the birthrate reaches the same level it had been in 1925. In 2025 there will be a growing number of 75-year-olds, and an increase in 80-year-olds, but the cohort of those over 85 doesn't begin to grow until 2030.

One Size Does Not Fit All

A "market," by definition, is group who share characteristics and who are able or likely to purchase a given product or service. Using this definition as a way of understanding the market, it's easier to see that Mrs. Stackpole, an 87-year-old widow with neuromuscular disease who can no longer be cared for by her family, is not in the same "market" as Mr. & Mrs. Smith, who are also 87 years of age, yet who are not dependent on any ADLs.

Anticipating demand is specific to each market segment.

Age Ain't What It Used to Be

By far the most common error in estimating demand among older cohorts is to use the wrong benchmark age. Since 1864, demographers and others have used 65 years of age as some magical threshold of aging. In his heralded 1990 book, *Age Wave*, Ken Dychtwald used 65 as a threshold. However, the average age of relocation to assisted living is 86, and the average age of admission to a nursing home is

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Irving L. Stackpole

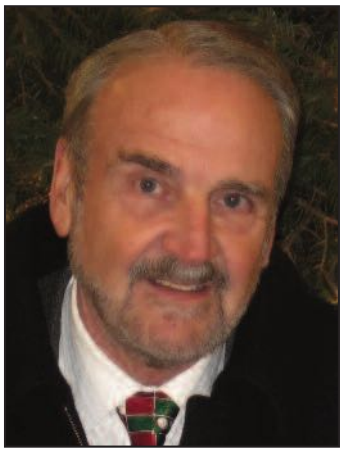
Welcome to our newsletter

THIS IS THE FIRST ISSUE OF THE NEW ENGLAND ADMINISTRATOR, INTENDED TO BE A RESOURCE FOR SENIOR CARE PROFESSIONALS IN THE REGION.

Included are columns by some of the most knowledgeable experts in healthcare, as well as articles we believe you will find interesting and informative. Beginning this issue, we look at the colorful history of our industry with a series entitled "Pioneers and Rogues."

Why, you may ask, should I care what happened or is happening in any state but my own?

It is not a coincidence that the six New England states have consistently been the leaders in the American College of Healthcare Administrators. No other part of the country shares the commonality of our region. Almost ¼ of all New England administrators hold more than one license, and most of them have worked in more than one state. From Eastport, Maine to Greenwich, Connecticut we are all part of a special relationship. And, although some of the articles relate to a single



W. Bruce Glass, FACHCA, CNHA, CALA

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Patient Driven Payment Model: Questions and Answers

by Kris Mastrangelo, OTR/L, MBA, LNHA

Q: Is there an actual table of rates that we can access?

Yes, per the Federal Register / Vol. 83, No. 153 Final Rule

Rate component	Nursing	NTA	PT	OT	SLP	Non-Case Mix
Urban Per Diem Amount	$103.46	$78.05	$59.33	$55.23	$22.15	$92.63
Rural Per Diem Amount	$98.83	$74.56	$67.63	$62.11	$27.90	$94.34

Q: Is the 25% group and concurrent therapy cap based on total therapy or are PT and OT evaluated separately?

To capture therapy delivery information over the course of a patient's entire Part A stay, as it relates to the concurrent and group therapy limit under PDPM, CMS will be adding Items 0425A1 – O0425C5 to Section O of the MDS.

Using a lookback period of the entire PPS stay, providers will report, by each discipline and mode of therapy, the amount of therapy (in minutes) received by the patient.

Providers should follow the steps outlined below for calculating compliance with the concurrent/group therapy limit:

Step 1 Total Therapy Minutes, by discipline (O0425X1 + O0425X2 + O0425X3)

Step 2: Total Concurrent and Group Therapy Minutes, by discipline (O0425X2+O0425X3)

Step 3: C/G Ratio (Step 2 result/Step 1 result)

Step 4: If Step 3 result is greater than 0.25, then the provider is non-compliant.

There will be no penalty for exceeding the 25% combined concurrent and group therapy limit. However, providers will receive a warning edit on their assessment validation report that will inform them that they have exceeded the 25% limit.

Kris Mastrangelo

The warning edit will read as follows: "The total number of group and/or concurrent minutes for one or more therapy disciplines exceeds the 25 percent limit on concurrent and group therapy. Consistent violation of this limit may result in your facility being flagged for additional medical review."

CMS will also monitor therapy provision under PDPM to identify facilities that exceed the limit, in order to determine if additional administrative or policy action would be necessary.

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Q: Will there still be a 3-day hospital admission required for coverage?

Yes, under Traditional FFS Medicare, eligibility, entitlement, benefit periods and skilled coverage criteria do not change under PDPM.

Q: NAC struggles with Section G. How do you suggest they will do with GG?

Review your process now. Many facilities have Rehabilitation Services code Section GG on the MDS, and it is often based on only the evaluation. The evaluation may occur on day one. The assessment is based on the usual performance over first 3 days of the stay. Many facilities cut the time for the assessment.

The Interdisciplinary Team should review their observations, documentation, and speak with resident/family and direct caregivers. Section GG is scored based on the patient's usual performance, therefore the Interdisciplinary approach is critical.

Q: With PDPM, what will be the best way for a facility team to measure therapy involvement/utilization to ensure appropriate levels of utilization are occurring and supported for our residents?

CMS expects that there is no significant change in the way care is provided to the SNF patient. This will be monitored and assessed via the discharge MDS that reports all therapy days and minutes since the start of the stay to the end of skilled stay.

Measure progress towards goals, functional outcomes, patient and family satisfaction to validate that clinically appropriate reasonable and necessary care is provided.

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PIONEERS & ROGUES: FORREST McKERLEY 1940-2012

Our profession has been blessed with a number of pioneering leaders in New England. These individuals, along with a rogue's gallery are part of the colorful history of senior care in New England. From time to time we will take a close look at some of these individuals—both heroes and rascals. This issue we feature Forrest McKerley—who cast a giant shadow in New Hampshire—not only in healthcare, but as an entrepreneur and philanthropist.

by W. Bruce Glass, FACHCA, CNHA, CALA

Forrest Dawson McKerley grew up in Penacook, New Hampshire and served in the Air Force in the Korean War. He later earned a bachelor's degree in business from UNH, and a Masters in finance from the University of South Carolina. Upon discharge from the Air Force, McKerley was an executive with American Express in Europe.

In 1946, his parents, David and Mary McKerley had opened a small nursing home, and when David's illness forced them to consider selling it, Forrest returned to New Hampshire in 1967 to take over the operations. His comment to the Concord Monitor was "It was the first time I ever took a cut in pay, but it was worth it!"

Instead, he and his brothers expanded to become the largest nursing home operator in the state. At a time when nursing homes were subject to numerous scandals, the McKerley Healthcare Centers set a standard for quality of care. Eventually they numbered 15, and were widely recognized as among the best in New England.

Unlike many entrepreneurs, McKerley was not your typical Type A. In spite of his success he remained modest and caring, with great concern for his residents and staff. When he sold out to Genesis in 1995 after 28 years, his response to an interviewer was "I've been running this company longer than a person should run a company. They need new ideas. They need new blood. Had this been a public company, I probably would have been fired."

Forrest McKerley and his mother, Mary McKerley.

Not only was he a successful businessman, but he was a generous benefactor to the community, and active in the state's Republican Party. Friends said McKerley made large gifts to New Hampshire institutions and many anonymous gifts to persons and organizations in need. Among his more significant gifts were

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Do you remember your first time?

by Ralph Peterson

"I FIXED A PROBLEM ALL BY MYSELF!"

I looked up and saw a young guy, early twenties with the biggest smile.

"It was a hard problem too," he said.

"That's good," the manager said. "Now maybe you can fix this guy's problem." He nodded toward me. I smiled.

"My problem's easy," I said. "I need silverware. Maybe a couple of paper plates." He nodded, continued smiling and eagerly put out his hand. I took it.

"I'm Tyler," he said.

"Ralph."

As we walked to the kitchen, I turned back to see if the manager was coming with us. He wasn't. I shook my head. "Bummer," I thought.

Tyler, still beaming from his victory, asked me how I was doing and what brought me to town. I told him I was great, and I was there for a race, but all I kept thinking about was trying to remember my first time.

The first time I solved a really hard problem…all by myself.

Do you remember your first time? I do. I was sixteen years old, working for a landscaping company mowing lawns.

One of the lawns we mowed, had a steep bank that was slippery and dangerous. There were even rumors of kids slipping under the mowers and getting their toes chopped off.

Not wanting that to happen to me, I tied a rope to the back of the lawnmower and, from

Ralph Peterson

the top of the bank, slowly lowered the mower down and then pulled it back up. When my boss saw what I was doing he came up and gave me a high five.

"That's the smartest thing I've seen," he said. I remember beaming from ear to ear, full of pride.

Okay, in retrospect it wasn't completely earth shattering. I mean, all I did was tie a rope to a lawnmower. However, you have to understand, I was only sixteen years old at the time, and it was the first time I had ever solved a problem at work, all by myself. And it felt amazing.

Suddenly, my boss had more confidence in me; heck, I had more confidence in me. I started to walk around with my shoulders back, my head held high, and looking for more problems to solve.

A couple of weeks later, my boss asked, "Have you ever thought about being in charge?"

Coincidence? I don't think so.

Ralph Peterson is a professional speaker & trainer in the field of management development. He is the author of "Managing When No One Wants To Work: Leadership Lessons from an Executive Housekeeper," and a regional director for Healthcare Services Group. Email him at Ralph@RalphPeterson.com.

Bored to death in a 5-star facility

Continued from page 1

recognize her at first. She was near the woman who calls out, "Help me, please," all day long, right next to the woman who always asks if I'm her son. She sat, motionless, on the edge of that puddle of sadness, that collection of empty souls whose life has been reduced to staring at a desk for hours. Her eyes were clenched tight, her hair, disheveled, and she was wearing a johnnie, with a blanket on her lap. A rather large nurse sat at the desk, shuffling papers and answering the phone.

This place has had perfect surveys for the last three years? I thought as I dragged a chair across the highly polished deficiency-free floor.

"Hi Mom," I tried to sound as upbeat as possible.

"Edison…" she looked at me, "I'm so bored." Tears rolled down her cheeks.

"Well, I'm here to do something about that. It is a gorgeous fall day out there. Let's get your coat and sit outside under that sugar maple."

"I want to go back to bed."

I didn't take no for an answer, and we got on the elevator. The administrator got on too, but did not acknowledge us. He turned his back and pressed the button for the first floor. I recognized him from his photo on the website. I could have introduced myself, but he seemed too busy to make small talk with a resident and family member. When the door opened he bolted towards his corner office. (A few months later, he would be promoted to a regional position, where I'm sure he established a wonderful example for other administrators to follow.)

My mother refused to go outside, so we sat near a clean picture window in the well-appointed lobby I had read about online, and we looked out at a bright display of cornstalks, pumpkins, and hay bales at the front entrance.

"Look at that blue sky, and those yellow leaves," I said as I pressed my face close to hers. Her cheeks were warm. "You have a fever, Mom. Let's get the nurse."

I brought her back to her room and walked over to the nurse's desk. The large nurse didn't look up, despite the fact that I was standing directly in front of her. I thought of all the family members who had told me the same thing about my nursing staff over the years. Now, I was one of them, and I understood.

"Excuse me, my mother, Mary Beaumont, needs a nurse."

"What room number?" she asked without looking up as if making eye contact with me would distract her from the important papers on her desk.

"306."

She leaned across the desk and looked left and right. "Your mother's nurse is on break. I'll tell her when she gets back onto the floor."

I felt the muscles in my neck and jaws tighten.

"My mother needs a nurse, now." I said with as much control as I could muster.

Nurse "large and in charge" pressed a call bell button on the desk console. "Suzie, you're needed in 306."

Suzie was very nice. She didn't know my mother, and at this point I wondered if anyone did. Mom was "306" to them. After taking her vitals she said, "I'll call her doctor. Her fever is high."

A soft-spoken nursing assistant helped my mother into bed. She called her "Mary," which made me feel better.

A few minutes later, my fa-

Continued on next page

NEW ENGLAND ALLIANCE

by W. Bruce Glass, FACHCA, CNHA, CALA

In 2012, the American College of Healthcare Administrators was in deep trouble. With the decline of the independent owners who had been the bulwark of the College, and some poor business decisions, the organization's very survival seemed doubtful.

Fortunately, several leaders stepped forward to restructure and revamp the organization, helping to shepherd ACHCA through its darkest days.

Here in New England, individual chapters continued to provide the national organization with strong support. Region One—now District One—had sponsored several educational programs around the region each year.

Steve Esdale, Bob Oriol, and others from New England acted to preserve and strengthen the existing relationship among the New England Chapters. Fearing that the national organization might not survive, they incorporated the New England Alliance for the purpose of providing financial support to National, while supporting the local chapters.

Continuing and expanding upon the existing format, three programs were presented every year—each offering 9 CEUs over a three-day period—along with social events. Soon these became regular fixtures in Portland, Maine each September, Woodstock, Vermont in January, and Newport, Rhode Island in May. Each has offered NAB-approved educational programs, receptions, and meals at very reasonable rates in desirable venues.

Over the years, the quality and locations have shown continued growth, which has enabled significant financial support to ACHCA, and provided valuable assistance in the rebirth of the Maine and New Hampshire Chapters.

For more information, visit the website: www.thealliance.org and make plans to attend the Fall Conference at the Portland Regency on September 25 to 27, 2019.

Upcoming Events

Thursday, June 13, 2019, NY Chapter
Joan Cassidy Dinner

Wednesday, July 10, 2019, CT Chapter
Board Meeting

Wednesday, Sept. 11, 2019, CT Chapter
Board Meeting

Wednesday to Friday, Sept. 25 to 27, 2019
New England Alliance Fall Conference
Regency Hotel in Portland, Maine

Friday, Oct. 11, 2019, MA Chapter
Annual Golf Tournament

"Perfect" facilities can be terrible

Continued from previous page

ther arrived, and right behind him were the EMTs. Mom's doctor had decided she should go to the ER.

We were in the ER for a few hours, with a curtain pulled around us. I heard the nurses at the desk, laughing about going out the weekend before. One of them drank too much, she admitted. She felt sick the whole day. I wondered if they knew everyone could hear them, or if they had grown immune to the struggles of people lying on gurneys nearby. Next to us I heard an old man praying in Portuguese.

Mom drifted off, and I could see she was transitioning between worlds. Her doctor and a kind ER nurse visited and shared that Mom had an infection, probably MRSA or C-diff. Their hushed tones conveyed how grave her situation was.

I held her hand and spoke to her. I thanked her for all she had done for me, and I told her I loved her. My father cried. After a while, she passed away.

Her cause of death was listed as sepsis, but I believe she lost all desire to live soon after she was admitted to the nursing home.

A few days later, my father and I went back there to pick up her things. The social worker met us in the lobby and handed us two items: a duct-taped cardboard box that read "Medium Adult Briefs," inside of which were her clock radio, rosary beads, hairbrush, and photos of her grandchildren (my children). She also handed us a trash bag with my mother's clothes, including a favorite sweater I gave her one Christmas. I remember thinking that nothing says "Your mother's life truly didn't matter to us," like getting her precious few belongings back in a Hefty garbage bag.

Five stars, perfect surveys, Joint Commission accreditation.

I felt angry for many days after that, and my family was angry with me for choosing such a horrible place for Mom to live her last days. Then, a colleague listened to the story and changed my perspective. "Do you realize what an incredible gift your mother gave you on her last day on earth?" she asked. "She opened your eyes and your heart. Now you will make sure that no one entrusted in your care will ever suffer as she did."

As leaders in long term care, we are conditioned to achieve perfect surveys.

It has been years since these events occurred, and I hope I have lived up to that lesson. As leaders in long term care, we are conditioned to achieve perfect surveys and attain five star ratings, however, when we focus solely on compliance and not on the well-being of the unique human beings in our care, we miss the true essence of our duty entirely. The best leaders learn to do both.

The system we work in is so flawed and subjective even those that are judged as "perfect" can be terrible. Conversely, there are communities that don't do as well by government measures but have boatloads of heart and soul. In either case, and for everything in between, it is up to us as leaders to join with our staff members and carry this broken system on our backs. In the end, I'd like to think that it's worth it, for someone's parent who reminds me of mine.

Edison Beaumont has over 35 years experience as an executive in eldercare, and has the scars to prove it.

Hope is not a strategy when tracking demand for long-term care

Continued from page 3

82 to 87. No responsible researcher is suggesting that 65 is a reasonable threshold for long-term care demand, or that a high proportion of those 65-74 are electively choosing senior housing. The target age cohort is over 85.

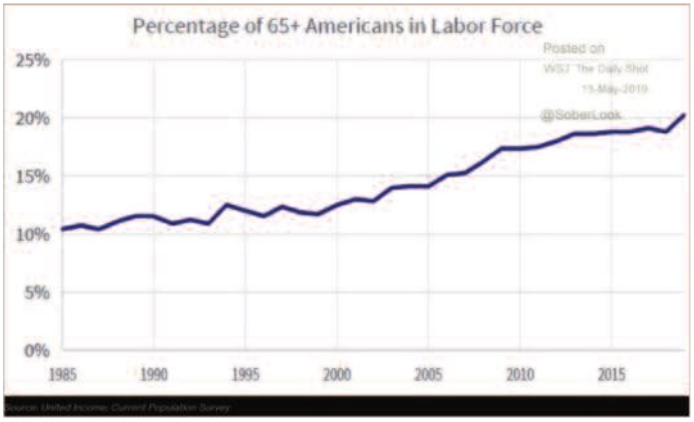
In fact, workforce participation rate among those 65+ years of age has been creeping up steadily, from 11% in 1985 to over 20% currently. This is largely due to the 65 to 74-year-old cohort, many of whom are highly educated professionals and among the "creative class" who are choosing to work.

Penetration & Acceptance

It has been my sad experience to read many articles and market reports suggesting that, in each marketplace area, the lower the penetration of a product, the greater the opportunity. The logic goes something like this: If there aren't many people who are using assisted living or age restricted independent living, then there's a bigger potential market. But this logic is fatally flawed.

The marketing science clearly shows that the greater the level of penetration of any given product or service, the higher the acceptance. Marketplace areas where penetration or acceptance is at or below the national threshold (approximately 12%) may represent marketplace areas that are highly resistant to further acceptance. There are marketplace areas where penetration and/or acceptance will never reach national averages because of cultural, socioeconomic, and financial issues.

Acceptance is the Achilles' heel of virtually all non-need driven seniors housing.



What Do We Think of Residential Long-Term Care?

In his brilliant 2006 book, The Culture Code, Clotaire Rapaille presents a systematic model for understanding how cultures and societies define reality. Dr. Rapaille refers to "culture codes" as the metaphors by which we understand and interpret important facts. Using this model, it's easy to see that most Americans view nursing homes and assisted living residences as "God's waiting room."

This overwhelmingly negative cultural metaphor was driven home when, over the course of three years, my company surveyed over 35,000 case managers in the United States on their attitudes about a variety of health and social care issues. When asked about nursing homes or long-term care, the overwhelming response was negative. If this is the attitude of the professional class responsible for accessing and recommending long-term care, it should be no surprise that the dominant cultural metaphor toward congregant seniors care of any type is, "Never!"

Those of you who remember the movie Gran Torino will know the scene where the daughter and her husband try to convince Clint Eastwood's character to leave his home for an assisted living residence. Suffice it to say, it does not end well.

While there are headwinds, there are opportunities.

"Hope" Is Not a Strategy

The planning, development, acquisition or marketing of long-term care and senior housing and services does not have to be a guessing game, and it must not rely on the optimism of those who already have skin in the game. Demographics is destiny, and the current decline in the age-qualified markets in the US was predicted by me and others in the 1990s.

Each service line or product in each area has a predictable future market or markets.

Recent closures of nursing homes points to deeper problems than the too-often blamed Medicaid payment rates. The current poor occupancy rates among market-rate independent and assisted living residences are due in large measure to a miscalculation of the demographics, acceptance, and demand in specific marketplace areas.

The Bottom Line

Market analysis must be done carefully and cannot be a cookie-cutter. To learn more, contact us. (See below.)

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Nursing Home Compare

It can be interesting to see how your state compares with others on cited deficiencies. Here are the latest numbers for the New England States. It is noteworthy that all are below the national average of 5.8—yet there are significant differences from state to state. Also, it is interesting how the numbers have changed since the last time they were compiled. Particularly, Massachusetts has increased, while Vermont has decreased. The numbers for the other states have remained relatively stable.

Connecticut	5.4
Maine	2.9
Massachusetts	5.0
New Hampshire	2.8
Rhode Island	1.6
Vermont	2.4

Welcome

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state, most are intended to be of general interest.

We hope you will agree, and make this publication a regular part of your professional reading matter. In order to keep up with the times, it is being published exclusively on-line, which enables us to provide more content and color at less cost.

If you have questions, suggestions, comments, or criticisms—or have an interest in submitting an article, please feel free to contact me. And thanks for reading this.

Bruce Glass
bruceglass@rocketmail.com

Evacuate! Rhode Island's St. Clare implements emergency plan

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For St. Clare, the problem was far greater. Immediate accommodations had to be found for 87 skilled and assisted living residents. At an average age of 86, and with multiple infirmities, uprooting these individuals presented a unique problem.

Mary Beth and her team sprang into action, implementing an emergency plan that had been rehearsed, but never expected to be needed. Available beds had to be located, transportation arranged, staff provided, and families notified.

Senior care is a close-knit fraternity, so neighboring administrators were quick to offer assistance.

The Rhode Island Healthcare Coalition began implementing previously rehearsed action plans. The Rhode Island Department of Health sent a response team to assist, while the staff quickly moved to deal with the crisis.

Rhode Island is a small state, and senior care is a close-knit fraternity, so neighboring administrators were quick to offer assistance. A stroke of luck (at least for St. Clare) was that there were over 600 nursing home and assisted living beds available. Beds were available for both nursing home and assisted living residents—though it meant reaching as far away as Providence, a distance of nearly 40 miles. In several cases, local family members were able to accept their relatives for a short period.

More than bodies had to be moved. Medications, equipment, clothing, and other essentials had to be sent with the residents. In addition, staff accompanied residents in many cases to supplement the personnel at receiving facilities.

As outside temperatures dropped into the 20s, the building became increasingly frigid. A sense of urgency, but not panic, prevailed.

Residents were moved from the cold upper floors to lower areas where the temperatures were less frigid until transportation could be arranged. Individual temperatures were closely monitored to assure all residents were safe and relatively comfortable.

EMTs assist with the temporary relocation of skilled residents at St. Clare Newport.
Sean Flynn, Newport Daily News

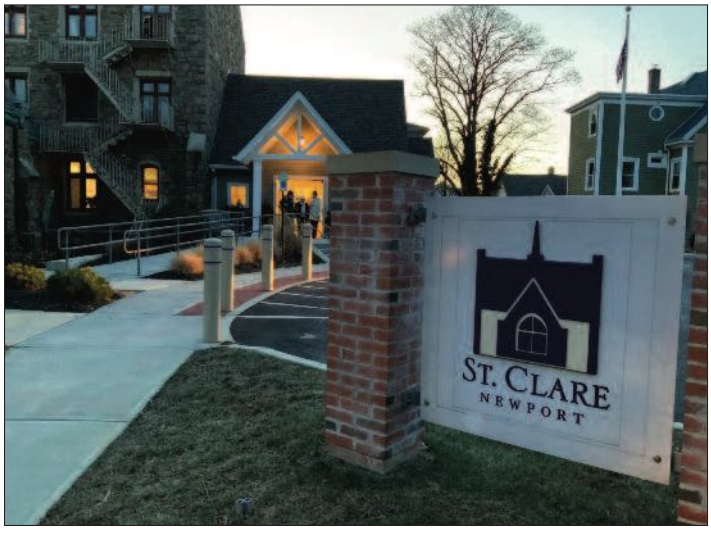
Ambulances summoned from six different companies gathered at a staging area two blocks from the Home. In addition, two of the receiving homes provided transport. Shortly, ambulances began to line up at the entrance to speed residents to their temporary abodes.

By 10:45 PM on January 22, the last of the transients had been sent off to 15 different facilities throughout Rhode Island.

Now it was up to remaining staff to monitor the premises to prevent damage from freezing while emergency crews from National Grid struggled to restore service. In addition, local authorities mandated a 24-hour fire watch.

Finally, on January 26, National Grid turned on the gas and relit pilots. Heat gradually returned to the building.

Beginning on January 27, the various facilities were contacted to schedule return of St. Clare residents, who gradually returned over the next two days. The last residents returned by 6:30 p.m. on the 29th.



Sean Flynn, Newport Daily News

Now it was necessary to begin the return to full operation. Some pipes had frozen, but fortunately damage was limited. Hot water continued to be a problem for some time, and various personal items and equipment had to be repatriated from the host facilities.

Then, there were the financial ramifications. Initial estimates were a cost of nearly $300,000, including damage, transportation, staffing, and loss of revenue.

Everyday operations in today's nursing home are an ongoing challenge, but it is only when a serious crisis strikes that the true worth of trained staff and dedicated professionals can be appreciated. St. Clare's staff and management demonstrated professionalism under the most difficult circumstances.

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More payment model questions & answers from The Medicare Expert

Continued from page 1

Q: How will ST frequency impact payment/scores?

You do not need to deliver ST for the SLP Component. In fact, all patients have a PT, OT, SLP, NTA, Nursing and non-Case Mix component/rate. The 5-Day MDS does not code therapy involvement the way you code now.

The SLP component is based on Speech-Language Pathology-Related Comorbidities, Acute Neurologic Clinical Category, Swallowing Disorder using items K0100A through K0100D, and Mechanically Altered Diet (while a resident) and Cognitive Impairment.

Q: Will there be 2 sections or columns in GG to distinguish between nursing and therapy functional scores?

No, Section GG will be completed as it is now. There will be 6 GG Items for calculating the PT/OT Functional Score and 4 GG Items used for the Nursing Functional Score. Some Self-Care and Mobility tasks are averaged. Under Section GG, increasing score means increasing independence. Max Scores: PT/OT: 6 items x max 4 points = maximum of 24 for the PT/OT Functional Score. Nursing: 4 items x max 4 points = maximum of 16 for a Functional Score.

Q: Who is responsible for doing the cognitive assessment? I see there is a component under SLP, what if SLP is NOT involved in the patient care?

The cognitive assessment may be done by a qualified clinician. A qualified clinician is defined as a healthcare professional practicing within their scope of practice and consistent with Federal, State, and local law and regulations.

The cognitive assessment and scoring are based on MDS coding of the BIMS or the CPS. Either a BIMS score or CPS score is necessary to classify the patient under the SLP component. The BIMS is completed by interview. The Cognitive Performance Scale (CPS) is based on the responses to the Staff Assessment.

Any degree of cognitive impairment contributes to the SLP Component.

- BIMS: < 12
- CPS Score: > 1

Q: If rehab is not providing services who will complete rehab section GG. Sill Nursing?

Yes, nursing will complete the rehab portion of section GG if therapy has not observed, assessed or treated the patient (as they will not know the usual functional status). Nursing will observe, review documentation, interview patient, family and direct caregivers.

Cognitive Level	BIMS Score	CPS Score
Cognitively Intact	13-15	0
Mildly Impaired	8-12	1-2
Moderately Impaired	0-7	3-4
Severely Impaired	-	5-6

Q: Can you group all other payor sources along with your Medicare A residents?

Reimbursement for group therapy varies based on practice setting and whether the services are covered under Part A (inpatient) or Part B (outpatient). Group therapy policies are further defined in local coverage determinations (LCDs) issued by Medicare Administrative Contractors (MACs).

Group therapy is defined for Part A as the treatment of 4 residents, regardless of payer source, who are performing the same or similar activities, and are supervised by a therapist or an assistant who is not supervising any other individuals.

For Medicare Part B, treatment of two patients (or more), regardless of payer source, at the same time is documented as group treatment. For all other payers, follow Medicare Part A instructions.

Q: Can OT address cognition or is it now going to be speech driven?

There is no change in clinical practice. The Cognitive impact is in the identification of the patient conditions to derive the SLP component. The cognitively impaired patient may not be receiving SLP services and the cognitive impairment contributes to the CMG for SLP.

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*

Forrest McKerley

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a faculty chair in economics at UNH and a training center at Concord Hospital.

After selling his nursing homes, he remained president of Secure Care, a company that provided medical safety equipment for nursing homes. In addition, he was instrumental in development of the Grappone Convention Center in Concord, which he declined to have named for him, and the Concord Marriott Hotel.

In 2005 McKerley was named Greater Concord Chamber of Commerce Citizen of the Year.

Upon his death in 2102, there was an outpouring of recognition from peers, family, former employees, and New Hampshire leaders.

Forrest McKerley cast a giant shadow in New Hampshire—one that extended well beyond his very successful leadership of the nursing home industry in the state.

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