New England
ADMINISTRATOR

December
2020

"The man with a new idea is a crank, until the idea succeds."
-Mark Twain

District One
ACHCA
American College of
Health Care Administrators

WE REMEMBER STEVE ESDALE

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Choosing your battles • Failure to thrive

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Isolation, Quarantine, Skilling, COVID-19, and ICD-10: Top 6 Things to Know

by Kris Mastrangelo, OTR/L, MBA, LNHA

HHI is receiving ongoing inquiries on the MDS Coding qualifiers for Isolation and Quarantine. Although it may seem simple, there is a difference between isolation and quarantine.

- Isolation is for patients with symptoms and or positive tests.
- Quarantine is for patients exposed but exhibits no symptoms.

According to the CDC, isolation is for people who are ill, while quarantine applies to people who have been in the presence of a disease but have not necessarily become sick themselves. Per the CDC, "Isolation separates sick people with a contagious disease from people who are not sick."

1. Isolation (Z29.0) and COVID-19 (UO7.1)

Coding isolation for a patient with an active infectious disease places them into an ES1 nursing category under both Medicare Part A and certain Medicaid Case Mix states. To properly code isolation on the MDS, the patient requires:

- Isolation for a minimum of one day. (Although the patient may be isolated for longer than one day.)
- MD Orders for isolation.
- Active Infectious disease ICD-10 coded:
  - On the UB-04 and
  - On the MDS (Section O. and I.)
- All treatments rendered in the patient's room with documentation to support said services are provided at bedside.
- Isolation cannot be coded if the patient is being "cohorted", meaning rooming with another patient.

Skilled (Medicare Part A) Observation and Assessment is Indicated when there is a reasonable probability or possibility for complications or the potential for further acute episodes. This references conditions where there is a "reasonable probability or possibility" for:

- Complications
- Potential for further acute episodes
- Need to identify and evaluate the need for modification of treatment
- Evaluation of initiation of additional medical procedures

Daily observations and assessments include but are not limited to, fever, dehydration, septicemia, pneumonia, nutritional risk, weight loss, blood sugar control, impaired cognition, mood, and behavior conditions.

Example of daily skilled documentation: "This patient requires daily skilled nursing observation and assessment of signs and symptoms related to exacerbation of COVID-19, pneumonia, and related medical conditions." Skilled observation is required until the treatment regimen is essentially stabilized, and the patient is no longer at risk for medical complications.

2. Quarantine and Skilled Care

Although a quarantined patient may not have symptoms, the mere fact the patient was potentially exposed to COVID-19 warrants daily skilled nursing to observe and assess for signs and symptoms of COVID-19.

Observation and assessment references conditions where there is a "reasonable probability or possibility" for the nurse to:

- Evaluate the patient's condition i.e., observe and assess for fever, body aches, loss of appetite,
- Identify acute episodes, and
- Identify the need for treatment (modifications).
- Initiate treatment changes

In addition, the nurse may provide observation and assessment of signs and symptoms related to:

- Dehydration,
- Septicemia,
- Pneumonia,
- Nutritional risk,
- Weight loss,
- Blood sugar control,
- Impaired cognition and
- Mood and behavior conditions.

Nurses need to document the defined assessment on a daily basis. This may include neurological, respiratory, cardiac, circulatory, pain/sensation, nutritional, gastrointestinal, genitourinary, musculoskeletal, and skin assessments.

In these situations, the nurse may write: "This patient requires daily skilled nursing observation and assessment of signs and symptoms related to COVID-19." Skilled observation is required until the treatment regimen is essentially stabilized.

3. Reimbursement Medicare Part A Skilled Care

The difference in reimbursement for accurately coding isolation for a patient with active infectious disease is depicted in the accompanying charts.

4. Reimbursement Medicaid Case Mix – D.C.

In D.C., the coding of isolation also impacts the Medicaid Case Mix Index. An ES1 Level for Isolation yields 2.22 CMI. Conservatively, the CMI Impact Isolation COVID-19 = ES1 versus CB2 = 2.22 - .95 = 1.27 increase.

Kris Mastrangelo

When identifying patients who are isolated and quarantined, it is imperative to assess if the condition warrants skilled care. Currently, each state uses its own Medicaid reimbursement system. Multiple states are collecting data in preparation for applying the PDPM model for usage.

5. ICD-10 Active Infectious Disease i.e., COVID-19

- The ICD-10-CM Diagnosis Code is U07.1, Virus Identified
  - U07.1 is a billable/specific ICD-10-CM code that can be used to indicate a diagnosis for reimbursement purposes.
  - ICD-10-CM U07.1 is a that became effective on October 1, 2020.
  - This is the American ICD-10-CM version of U07.1 - other international versions of ICD-10 U07.1 may differ.
- ICD-10-CM U07.1 is grouped within Diagnostic Related Group(s) (MS-DRG v38.0):
  - Respiratory infections and inflammations

Continued on page 18

Failure to thrive–the diagnosis in long term care

by Irving L. Stackpole, RRT, MEd

"FAILURE TO THRIVE" DESCRIBES A STATE OF DECLINE, often the result of chronic concurrent diseases and functional impairments. Long-term care in the US certainly warrants the diagnosis, "failure to thrive."

Most of these chronic conditions can be described as political, fiscal and cultural neglect. With 40+ percent of the COVID-19 related deaths in the United States occurring in congregate long-term care, decades of underfunding, neglect and negative cultural stereotypes have tragically converged. The reality of this carnage is inescapable, and cannot be glossed over with politics, public relations or (even worse) grim resignation.

Nursing homes and assisted living residences have lost occupancy & utilization, have lower revenues and face immense staff retention and recruitment obstacles because of the pandemic. And in spite of the fact that the situation was concocted almost entirely of political neglect, these same politicians call for review and reform, goaded on by ersatz public interest groups and media outlets who see an opportunity to leverage the situation for their own ends. Meaning more uncompensated direct and indirect costs of these already underfunded healthcare system stepchildren. And we haven't yet seen the tide of litigation, which is bound to swell as guilt-ridden and angry families seek to take "revenge" for the deaths of tens of thousands of their relatives. This collision of circumstances will certainly drive a steep increase in bankruptcies and closures, removing even more nursing homes and assisted living residences from the market.

Irving L. Stackpole

Saving long-term care includes:

- Structures – the property plant & equipment in most congregate, long-term care settings is old and unattractive. Most owner / operators don't have access to capital markets and would not be able to make the debt payments for the kinds of upgrades that have been put off for 30+ years.
- Labor – we don't have enough staff now, and the situation is only going to get worse. And this isn't a problem that will go away it more money is thrown at it (increased pay), but this is a deep-seated issue of workforce inadequacy.
- Programs – most of the programs in long term care aren't at all designed to meet the needs and desires of consumers or their families, but are, instead, designed to restrict government funding to a specific class of individuals and / or to monitor and control payment through utilization measurement.
- Technology – technologies, including "ambient assisted living" are currently available to enable surveillance and physical safety of consumers in their homes. Remote patient monitoring, digital health and telehealth solutions have clear returns on investment and (because of SARS-CoV-2 / COVID-19) are meeting with widespread acceptance and adoption.
- Information infrastructure – grocery stores have better technology than most congregate care centers. Country-wide investments in health information technology (HIT) for things like telemedicine and electronic medical records in the US and the UK have specifically excluded congregate long-term care. This ahs to change.
- Outcomes – the minimum data sets required of and recorded by long-term care centers are just that – minimum. There is no data about the overall outcomes of care. Even where the data about clinical conditions is recorded, (e.g., PDPM, PDGM), unlike hospitals,

Continued on page 8

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We remember Steve Esdale, a giant of the profession

by W. Bruce Glass, FACHCA, CNHA, CALA

Everything about Steve Esdale was outsize: his booming voice, his love of life, his dedication to the profession and ACHCA, his opinions, his loyalty to friends…and even his waistline.

After a protracted illness, Steve was lost to us in September.

In his ACHCA career he accumulated about every award available: Distinguished Administrator, National Chair, President of the Massachusetts Chapter, Regional Governor, Founder of the New England Alliance, and numerous chapter awards. He was a mentor and inspiration to many young administrators and, as noted in a McKnights article, a terrific pitchman for the College, as well as spokesman for the industry in his role as chair of the Massachusetts Senior Care Association.

Steve's background is equally interesting.

A former choir boy, he graduated to professional entertainer as part of the popular New England band, Minus One, as well as brief stints with Sha Na Na and Chuck Berry. He continued to perform as a DJ throughout his career, and delighted in speaking to groups within and outside the industry.

And then there was his time as a high school teacher before making his career change to senior care. That happened when his brother-in-law, an executive with the Flatley Company, offered him an opportunity as an administrator-in-training. At the time, New England entrepreneur Tom Flatley owned one of the largest real estate empires in the region which included six top-quality nursing homes in Massachusetts.

He went on to manage several of these homes, rising through the organization in parallel to his advancement in the College. Flatley soon recognized a unique talent, and promoted him to vice president, directing all six facilities. In a dynamic organization noted for burning out executives, Steve prospered with his brand of skill, dedication, and amiability. When Flatley eventually sold the homes, Steve moved on to lead other organizations.

Then when ACHCA was in crisis mode, Steve once again stepped up. Recognizing that the New England Region of ACHCA was strong even when National was in danger of collapse, he met with Bob Oriol, and several regional leaders to form the New England Alliance. Continuing the tradition of regional educational programs, the Alliance helped to maintain the College in the region and provided valuable support to the struggling National organization. About the same time, he joined Larry Slatsky, Lonnie Brisbano, and several others to help foster a renaissance of ACHCA.

Today, both ACHCA and The New England Alliance are prospering, due, in no small part to Steve's leadership. He leaves behind, not only a strengthened profession, but a host of friends and admirers. his supportive wife Gloria, and a widespread family.

Next month at the Annual Meeting of the Alliance in Woodstock, Vermont, the membership plans an appropriate recognition of his life and service: The opening cocktail party will be dedicated to his memory.

His like will not be seen again soon.

It is very hard to come up with just a few sentences to summarize the essence of Steve Esdale. He was a mentor. He had a sense of humor. He sang and enjoyed the spotlight, but only at times.

Steve focused on his vision, but knew that we needed what he called "doers" to make the vision happen. He loved Gloria, his wife, and his profession and his professional organization. He left the world a better place than he found it, and the same with his professional organization. He was serious about what was important to him, and yet, at the Philadelphia Convocation when he was Cahir, he entered with the fife and drum corps dressed as Benjamin Franklin, proving once again he was unique. I will truly miss his laugh and his wisdom…and his friendship.

– Michael Hotz, former Chair ACHCA

It was my pleasure to have known Steve Esdale and hi family for over 30 years. He was the most dedicated person I ever knew to long term care and the College. His leadership and long time commitment is a model to be followed and admired by all in the healthcare profession.

– Lonnie Brisbano, former Chair ACHCA:

Steve Esdale

Distinguished service

by Bill McGinley, CNHA, CAS, CALA, HSE, FACHCA, President and CEO of ACHCA

Steve was a friend and mentor to me. Despite his often politically incorrect demeanor and "old school" ways, Steve did not have a mean bone in his body. His passion for our organization and the profession of long term care administration was unmatched. While he liked to party and have a good time, he also enjoyed his quiet time. I will fondly remember many quiet late night dinners and drinks with just Steve and our spouses.

The following is my nomination of Steve for the Distinguished Service to ACHCA Award, which he received at Convocation in Las Vegas in 2014.

Steve Esdale has devoted his entire professional career to service to the College. Steve became a licensed nursing home administrator in February 1985 and less than one year later joined the ACHCA. He has been a member for 34 years.

He has been associated with the MA Chapter ACHCA board since the early 1990s and has served as the MA Chapter board president twice: 1995-1998 and 2003-2006. As board member and officer he has led one of the most successful chapters of the College. The MA Chapter ACHCA has won the

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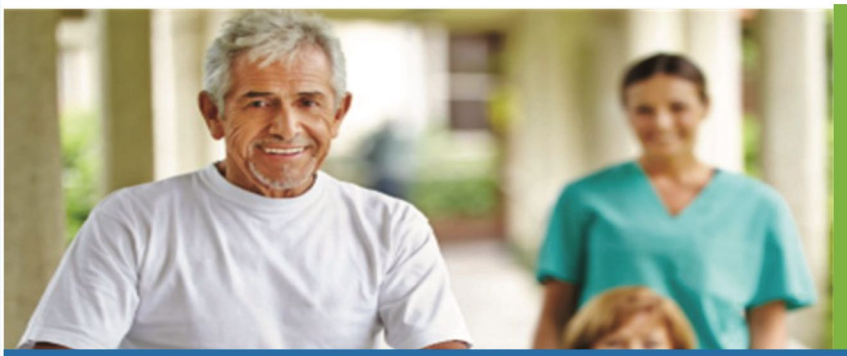

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MORE REMEMBERANCES OF STEVE ESDALE

Steve Esdale served as Board Chair during a critical time: 2008. ACHCA was forced to make some difficult decisions to bring the organization back from bankruptcy. Steve worked with the Board to reposition his beloved "College." He guided the College to become virtual long before others. He led a plan to repay overdue chapter dues and he oversaw the restructuring of the district organizations.

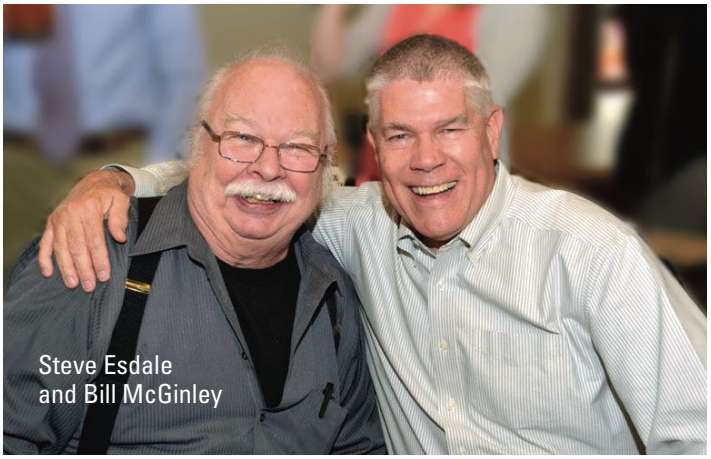
Steve loved the College with great gusto. He retained his iconic gov1 email so many years it became emblematic of his professional identity.

He was truly "Mr. College."

– Marianna Grachek, Former ACHCA CEO

Steve Esdale has been a leader in the New England long term care community for my entire career–from my days as a young lawyer working with nursing homes to our last time together at the new England Alliance Winter Meeting in Woodstock, VT. I valued his friendship, deep concern for the industry and the families it serves…and his sense of humor. He knew everybody, remembered details about our families, and encouraged the fellowship among the profession. They don't make many like Steve. He will be missed.

– Larry Vernaglia, Chair, Healthcare Division Foley and Lardner LLC:



Steve Esdale and Bill McGinley

Honoring Esdale's service

Continued from page 6

Chapter Excellence award each year from 2007-2011. The MA Chapter has always had among the highest attendees at each Convocation thanks to Steve's advocacy. He has ensured that the chapter is a strong financial organization and contributes to ACHCA. In fact the MA Chapter, under Steve's leadership, has been among the highest of all chapters in terms of Convocation attendance and financial support. Between the years 2003 and 2013 the MA Chapter reimbursed its members $134,000 to attend Convocations and contributed close to $60,000 in direct Convocation sponsorships.

He has worked tirelessly for the College on both a national and regional level. When the College had regions he was the Governor of Region 1. When regions were eliminated by the College he was the driving force behind the creation of the New England Alliance of ACHCA Chapters (now known as the New England Alliance). This Alliance has allowed for a regional cohesion of the New England Chapters and holds three annual regional conferences that are extremely well attended by College members from the six state region. The New England Alliance has also been a major financial contributor to the ACHCA Convocation for many years.

Although I do not know all of the dates, Steve served on the board of ACHCA for many years, serving recently as the Chair of the Board of Directors. He has been relentless in his promotion of the College's goals and has done as much or perhaps more to contribute financially to its success through his efforts with the MA Chapter, the Alliance and his many fun fundraising events at Convocation.

I sincerely believe that there is no one more deserving of a Distinguished Service to ACHCA Award than Stephen Esdale.

Long term care's failure to thrive

Continued from page 4

and medical practices there's no attempt to measure customer or consumer satisfaction.

- Economics – how will care be funded? The most important component of any long-term care operating budget is labor. The human resources needed to care for vulnerable elderly represents 60 – 80% of every long-term care Operating Statement. These individuals are often poorly paid, foreign workers at the bottom rung of the socio-economic ladder. Why? Because operators are paid as little as possible, based on the "heads in the beds" or the (truly perverse) insurance or pension category of the consumer. A few bad actors aside, long-term care workers are paid so little not because of greedy owners but because the system doesn't allow the owners to pay them more!

We need to save the sector, and the current COVID-19 crisis is an inflection point where thought-leaders can and should step up and speak out. Join us, speak out for change and become part of the dialogue.

Irving Stackpole RRT, MEd is the President of Stackpole & Associates, marketing, market research and training firm at www.StackpoleAssociates.com. He can be reached directly at: istackpole@stackpoleassociates.com.

ASSISTED LIVING IN NEW ENGLAND

State	Facilities	Avg. Rate
CT	56	$5575
ME	69	$4950
MA	257	$5829
NH	143	$5103
RI	63	$4350
VT	22	$4774

The New England Alliance Conference Calendar

Note that the in-person annual meeting scheduled for January 13 to 15, 2021 has been cancelled.

Spring Regional Conference
Newport Harbor Hotel & Marina
Wed., May 26 to Friday, May 28, 2021

Fall Regional Conference
Portland Regency Hotel
Wed., Sep. 22 to Friday, Sep. 24, 2021

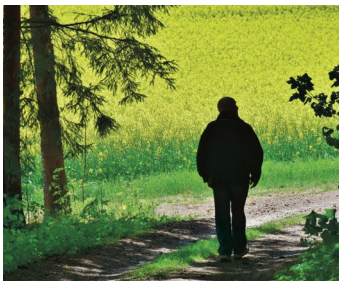
For more details: thenealliance.org

Push back against ageism and aging

by Sheldon Ornstein Ed.D, RN, LNHA

Ageism and aging is stereotyping and discriminating against individuals or groups on the basis of their age. The term was coined in 1971 by Robert Butler to describe discrimination against seniors, and patterned on sexism and racism. Butler defined "ageism" as a combination of three connected elements: prejudicial attitudes toward older people, old age, and the aging process. There are also other discriminatory practices against older people, such as institutional practices and policies that perpetuate stereotypes about older people.

Contrary to common and more obvious forms of stereotyping such as racism and sexism, ageism is more resistant to change. For instance, if a child believes in an ageist idea against the elderly with few people correcting him, then as a result, he will continue to grow into an adult believing in ageist ideas. In other words, ageism can become a self-fulfilling prophecy.



Ageism beliefs against the elderly are commonplace today. For example, when an older person forgets something, he or she could be quick to call it a "senior moment," failing to realize the ageism of that statement. People also often say ageist phrases, such as "dirty old man" or "second childhood" of which elders miss the negative undertones. On the other hand, when elders show greater independence and control in their lives, defying ageist assumptions grows stronger.

Labor regulations also limit the age at which people are allowed to work and how many hours and under what conditions they may work. Age discrimination in hiring has been shown to exist in the U.S. The Equal Employment Opportunity Commission's first complainants were female flight

Continued on page 16

PIONEERS & ROGUES: Synergy's Larry Lipschutz

by Edison Beaumont

I'll bet you thought that all the rogues were from the 1960s and 1970s. Alas, it's not so. Here is the tale of one of the worst–and it's not from decades ago.

The first time I read about Larry Lipschutz was in an article in the NY Daily News about his efforts to get back a $100,000, 7-carat diamond ring from a woman he married, after learning that she was also married to someone else. It's a true story.

The second, third, fourth, fifth, and sixth times were in articles spanning from 2015-2019 in the Boston Globe, in a series about the business Lipschutz owned: Synergy Health Centers. It seems that Synergy, based in New Jersey, had run afoul of the Massachusetts Department of Health for deficient care and treatment of residents in the eleven nursing homes the company owned in the state.

As for Mr. Lipschutz, he paid himself a salary of $1.8 million from their Brockton facility, (no wonder he can afford a 7-carat diamond!) while Lipschutz's son "extracted $900,000…as payments to a realty company and four management firms he owns."

The Synergy owners marketed their organization aggressively to physicians, inviting them to their $25,000 suite at Gillette Stadium to watch the Patriots play, while cutting back on essentials such as adult briefs, fresh fruit, wound care supplies, linen, and staffing for the 1200 residents with whose care they were entrusted.

By 2018, two Synergy homes were listed as focus facilities by CMS, meaning they were among the worst in the country. As financial conditions worsened, employees' paychecks bounced, and medical claims were rejected because the company failed to pay health insurance premiums. Eight of the homes were placed in receivership. Months later, two buildings closed, and the rest were put up for sale. Several of these homes had formerly been among the finest in the Commonwealth

But there is always a human toll, and in this case, five resident deaths were attributed to care and treatment failures at Synergy buildings. In one case, a resident fell at least 20 times, with the final fall proving fatal. Several families sued and settled with the company.

The patterns are all too familiar to those of us who have toiled in this field. Owners that have never run nursing homes come in from out-of-state. Shadow companies are set up to share the proceeds. Inevitably, family members are taken care of in the process. Marketing becomes a high-flying strategy of rubbing elbows with the rich and famous, rather than building credible relationships with community referrers.

Over the years, too many have made the mistake of assuming that elder care is a relatively simple business model. It is not. And when the chickens come home to roost, these owners cut their losses, file for bankruptcy, and move on try something else. But the damage is done. Lives and livelihoods are lost. More scrutiny and regulation falls on the rest of us. Those who are principled owners and operators are lumped in with the rogues in the eyes of the public.

Larry Lipschutz and Synergy will forever dwell in the rogues' gallery. For shame.

Choosing Your Battles

by Ralph Peterson

"Sometimes you have to choose your friggin' battles," Mike said shaking his head with a half-smile. He watched me closely, hoping I agreed with him. I nodded and laughed.

"Sure," I said. "As long as you are okay with losing the battle." He laughed, then paused as he thought about what I said, which made me laugh.

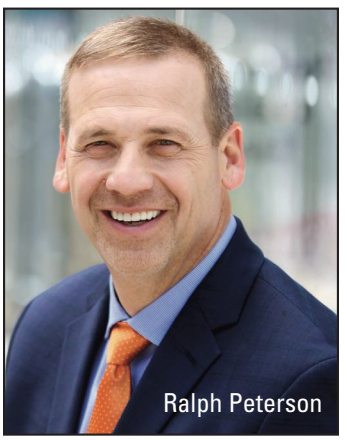
"Ralph, I can't fight every single battle," he said, shaking his head. "If I did, I'd never get anything done around here."

"Ha!" I snorted. "I'm not so sure that's true," I said. "But I understand what you mean."

Several years ago, a friend of mine bought me a book called: "Don't Sweat the Small Stuff," by Richard Carlson (Hyperion, 1996). As an aside to the main title, the author added a small subtitle that read: "and it's all small stuff." As if to say that we shouldn't sweat anything.

My friend said his wife had bought him a copy of the same book a year earlier. Just after he was promoted to a management position for the first time. She said she thought it would help him focus on what is important. He thought it did.

He said that when he read it, he thought of me. I didn't know if that was a compliment or not, so I just thanked him for thinking of me and took the book; but I never read it. The title alone was enough for me to know that it wasn't for me. I've been managing for way too long, and I know better.



Ralph Peterson

If you are one of those people that believe all the hype about not sweating the small stuff or that choosing your battles is the best way to be in charge, it is not your fault. This piece of sage advice is as common in management as the phrase "Break a leg" is in theater. Of course, in theater, they are being ironic. In management, they're not.

However, this concept of not "sweating the small stuff" or "choosing your battles" in management, will, if you are not careful, bite you in the butt. And I'm not talking about a small bite that will feel better with a little rub and some aspirin. No. No. I'm talking about the kind of bite that will make you spin around, loose your balance, and fall headfirst off that pedestal from which you manage.

The first time I realized how counterproductive this practice of choosing your battles was, I was being written up for how poorly my team was doing. I was fairly new at managing and my District Manager, trying to be helpful while writing me up, asked me to go through all the job routines to see if there was something I was missing or misunderstanding about what everyone was supposed to be doing. I wasn't. I knew all the job routines like the back of my hand.

He looked at time and attendance records to see if people were coming in late or leaving early; they weren't. He looked at project calendars and schedules and talked ad nauseam about each one. However, it wasn't until we started walking around that he found the problem; it was me.

Without even realizing it, I was letting people get away with all kinds of little things that made it nearly impossible for them to get their jobs done. I let people take longer breaks, cut corners, move from one project to another without finishing any of them and on and on.

When he asked me why, I said, "I thought you were supposed to choose your battles." I remember him shaking his head and laughing.

"Who the hell told you that," he said. I shrugged, and with a smile I admitted that I didn't know.

Ever since that conversation, and write up, I have learned a lot about what can happen when managers don't sweat the small stuff, or when they choose their battles. It is not

Continued on next page

Peterson says DO sweat the small stuff, DON'T choose your battles

Continued from preceding page

good and can have dangerous consequences.

Consider this: One of the most iconic rock and roll bands of the 1980's, Van Halen, spent most of the 80's touring all over the world. As part of their contract, they had one very specific stipulation: They didn't want any brown M&M's.

Tucked in the pages and pages of legal jargon, logistical specifications, and accommodation requests, Van Halen put in their contract, that they wanted a bowl of candy M&M's in their dressing room. However, in big capital letters they wrote: "WARNING: ABSOLUTELY NO BROWN ONES." And they were serious. The contract further stated, if they found any brown M&M's in the bowl of candy, the concert venue would forfeit their entire fee.

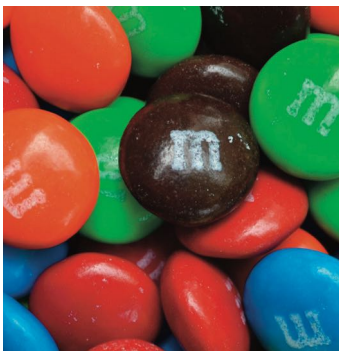
To an outsider, this might sound like an odd request, or worse, as an example of how unreasonable bands could be, just because they were famous. This was not, however, the case with Van Halen.

At the time, Van Halen was touring with a very large, state-of-the-art and dangerous light show. Therefore, it was extremely important that the venue's production team followed the safety and logistical guidelines in the contract. To ensure they read the entire contract, the band added the brown M&M clause. That way, all the band had to do was go into their dressing room, grab the bowl of candy M&M's and be able to see right away if the management team, had, in fact, read the entire contract.

Van Halen knew, if the production's management team did not "sweat the small stuff," or they were the type who "chose their battles," they would likely miss some very large stuff which could result in a dangerous situation for both the band and their fans.

In the end, most managers who "choose their battles," usually do so for two reasons. Some managers choose their battles based on the size of the issue. They tend to believe in the notion that it is best not to "sweat the small stuff." They think some issues are too small to cause big problems. They are wrong. Small things can build up over time, and when they do, all kinds of unintended and sometimes really bad things, can happen.

Other managers choose their battles based on whether or not they think they can win.



In this instance, if a manager doesn't think they can win the battle, then they won't see any reason to fight it. In fact, they will go out of their way to avoid it. This too is a problem. While there is some truth in the statement, "You can't win every battle." The point of choosing to fight a battle in management is not to win, but to fight.

This excerpt is from Ralph Peterson's latest book: "The Good Manager: Being Great is Overrated!" (Four-Nineteen Press, 2020) For more information visit: www.ralphpeterson.com

Career ladders in long-term care services and support

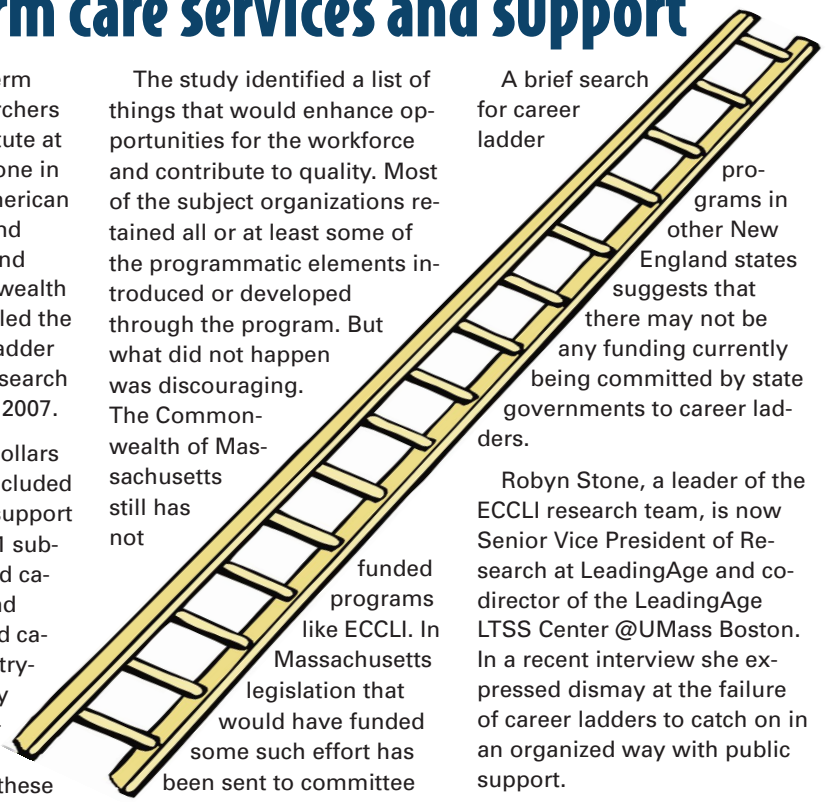
K.R. Kaffenberger, PhD

Recruitment and retention of frontline workers in long-term services and support is an ongoing problem for skilled nursing facilities, assisted living facilities, and home health care providers. One prospective solution is the use of career ladders to offer entry-level workers the promise of an opportunity to do more sophisticated work and be better paid.

In its report, "Career Ladders for Long Term Care Workers," The Bell Policy Center, a public policy think tank in Denver, defines career ladders as "specific paths which allow workers to advance to higher paid and skilled positions within a given field." Many of us think of career ladders as being especially important for certified nursing assistants (CNAs) and for home health aides (HHAs).

The only full-blown study of career ladders in long-term care was done by researchers at the Gerontology Institute at UMass Boston. It was done in conjunction with the American Association of Homes and Services for the Aging and funded by the Commonwealth Corporation. It was entitled the Extended Care Career Ladder Initiative (ECCLI). The research report was presented in 2007.

With about 5 million dollars in funding, the project included an array of subject and support organizations. Each of 11 subject organizations created career ladders for CNAs and HHAs. Some also created career ladders for other entry-level staff such as dietary and housekeeping workers. Additional skills training was offered for these and other workers. Community colleges and other training and education organizations were part of the project.



The study identified a list of things that would enhance opportunities for the workforce and contribute to quality. Most of the subject organizations retained all or at least some of the programmatic elements introduced or developed through the program. But what did not happen was discouraging. The Commonwealth of Massachusetts still has not funded programs like ECCLI. In Massachusetts legislation that would have funded some such effort has been sent to committee for study during the current session of the General Court. In early iterations it was also set aside.

A brief search for career ladder programs in other New England states suggests that there may not be any funding currently being committed by state governments to career ladders.

Robyn Stone, a leader of the ECCLI research team, is now Senior Vice President of Research at LeadingAge and co-director of the LeadingAge LTSS Center @UMass Boston. In a recent interview she expressed dismay at the failure of career ladders to catch on in an organized way with public support.

Stone sees at least three reasons why either the public or

Continued on page 19

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Challenging physician judgment: Is your institution exposed to False Claims Act liability?

by Michael J. Tuteur, Lisa Noller, and Olivia King

Many health care providers treating senior patients rely on Medicare reimbursement and undertake significant measures to ensure proper billing and compliant practices. However, providers across the country, including skilled nursing facilities (SNF), may soon be subject to increased liability under the False Claims Act (FCA) depending on the outcome of a case recently presented to the U.S. Supreme Court.

The Centers for Medicare and Medicaid Services (CMS) requires that physicians certify the medical necessity of many services as a precondition of reimbursement. For instance, CMS requires that physicians certify that a patient is terminally ill (meaning the patient has six months or less of life) before the agency will reimburse for hospice services. Likewise, CMS requires physician certification for certain covered post-hospital extended care services provided by SNFs.

Historically, CMS has indicated in the hospice context that physicians need not worry about liability due to challenges to their good faith clinical judgment. See CMS, Hospice Care Enhances Dignity And Peace As Life Nears Its End, CMS Pub. 60AB, Transmittal AB03-040 (Mar. 28, 2003) https://bit.ly/2DB9JtY ("CMS Pub. 60AB"). But, a recent federal Court of Appeals decision, "Care Alternatives v. United States (Care Alternatives)," 952 F.3d 89 (3d Cir. 2020), has called into question this assurance, and the outcome of the case could have significant implications on providers in New England.

The FCA prohibits submission of false claims for reimbursement by the federal government, including to CMS. Violation of the FCA can result in significant penalties and exclusion from participation in the Medicare program–a deathblow for many health care providers.

To successfully bring a FCA case, the plaintiff (either the government or a so called "qui tam relator"–i.e., an individual whistleblower) must prove the claims at issue were "false." The nation's courts are split as to what constitutes a false claim, and specifically whether a physician's clinical judgment as to medical necessity may be deemed "false" for purposes of FCA liability. While "objective falsity" is not in the FCA itself, practitioners and some courts recognize it as a legal theory that there must be objectively verifiable facts to prove that a claim is false. For those courts that have adopted an objective falsity standard, a physician's good faith clinical judgment generally may not be considered false, because clinical judgment is not objectively verifiable.

This issue is now before the U.S. Supreme Court in "Care Alternatives." In this case, four non-physician employees of Care Alternatives, a New Jersey based hospice provider, brought a qui tam action alleging that Care Alternatives submitted false claims for patients who were not terminal, and thus not eligible for Medicare hospice benefits. The plaintiffs relied on the expert testimony of one physician who reviewed medical records and determined that the terminal illness certifications for some number of patients were not adequately supported by underlying medical need. In essence, the plaintiffs argued the certifying physician's medical opinion was false, and thus rendered Care Alternatives liable for FCA penalties.

Violation of the FCA can result in significant penalties and exclusion from participation in the Medicare program–a deathblow for many health care providers.

Before the Third Circuit Court of Appeals, Care Alternatives argued that proof of objective falsity would be necessary to main-

Continued on next page

Michael J. Tuteur

Olivia King

Lisa Noller

Is your institution exposed to False Claims Act liability?

Continued from preceding page

tain the claim, and a physician's clinical judgment may not be deemed false for the purpose of FCA liability. Specifically, in support of its argument, Care Alternatives claimed that determining prognosis of life expectancy is an inexact science, and cited to CMS guidance that physicians need not worry about liability based on good faith clinical judgment. Care Alternatives further argued that CMS recognizes the imprecise nature of predicting life expectancy by allowing hospice benefits to patients that live past the six month period constituting terminal illness, provided that a physician recertify that the patient is terminal–bolstering its position that a claim must be objectively false before it is material to a CMS decision not to pay it.

The Third Circuit Court, however, ultimately determined that a physician's medical judgment could be deemed false, meaning objective falsity is not necessary for FCA liability. Specifically, the Third Circuit found that a certification of medical necessity could be considered false if a jury determined that an expert physician's review of the same medical records was more persuasive. In particular, because "false" is not defined in the FCA, the Third Circuit turned to common law, and found that an opinion may be false for purposes of liability. The Third Circuit also cited to United States v. Paulus, in which the Sixth Circuit Court of Appeals held that medical opinions "may trigger liability for fraud when they are not honestly held by their maker..." 894 F.3d 267, 275 (6th Cir. 2018).

The Third Circuit's decision contrasts with the decisions of other circuit courts that have found that plaintiffs must prove objective falsity to render a claim actionable under the FCA. For instance, in "United States v. AseraCare," a similar case involving a hospice provider, the Eleventh Circuit Court of Appeals determined that a difference of reasonable opinion between physicians is not sufficient to render a claim false for the purpose of the FCA. 938 F.3d 1278, 1301 (11th Cir. 2019). The Fourth, Seventh, and Tenth Circuits have also explicitly adopted an objective falsity standard. In contrast, both the Ninth and Third Circuits have explicitly rejected the objective falsity standard. This circuit split was the basis for Care Alternatives' petition for review by the U.S. Supreme Court. The Supreme Court will announce in the coming months whether it will accept Care Alternatives' petition and review the Third Circuit's decision on the merits.

The outcome of Care Alternatives could have significant implications for health care providers, including providers in New England. If the Supreme Court grants Care Alternative's petition for review, and then determines that objective falsity is not a necessary element under the FCA, providers may be subject to increased litigation risk. Specifically, if objective falsity is not necessary, a plaintiff could reach a jury merely by finding an expert physician who was

Continued on next page

Ageism and aging stereotypes are no laughing matter

Continued from page 9

attendants complaining of (among other things) age discrimination. It was also found that firms are more than 40% likely to interview a young adult job applicant than an older job applicant.

Ageism has significant effects on the elderly and young people. The stereotypes and infantilization of older people by using patronizing language affect older people's self-esteem and behaviors. After repeatedly hearing a stereotype that older people are useless, they may begin to feel like dependent, non-contributing members of society. They may start to perceive themselves in terms of the looking-glass self (i.e. in the same ways that others in society see them).

Studies have also shown that when older people hear these stereotypes about their supposed incompetence and uselessness, they perform worse on measures of competence and memory. These stereotypes then become self-fulfilling prophecies. The research further declares that the older individual might also engage in self-stereotyping, taking their culture's age stereotypes to which they have been exposed over the life course, and directing them inward towards themselves. Then this behavior reinforces the present stereotypes and treatment of the elderly.

Many overcome these stereotypes and live the way they want, but it can be difficult to avoid deeply ingrained prejudice, especially if one has been exposed to ageist views in childhood or adolescence.

A final thought on the subject: Implicit ageism is the term used to refer to the implicit or subconscious thoughts, feelings, and behaviors one has about older people. These may be a mixture of positive and negative thoughts and feelings, but gerontologist Becca Levy, reports that they "tend to be mostly negative."

So what can an elderly person do when bombarded with ageist comments? The answer is to push back with positive replies by challenging the negativity of someone who is either ignorant about ageist comments and their effect, or finds it humorous to offend by suggesting, "It's just a joke, so lighten up, I didn't mean anything offensive."

My reply: "Oh really?!"

Over a 50+ year career as a nursing director and nursing educator Sheldon Ornstein, Ed.D, RN, LNHA, has received numerous awards, including Nurse Administrator of the Year from NADONA. He has had numerous articles published in the Journal of Gerontological Nursing, Nursing Outlook, and the Journal of the New York State Nurses Association. He is a frequent lecturer on aging at various community and college settings.

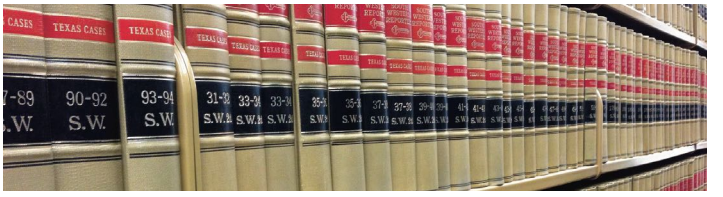
False Claims Act liability

Continued from preceding page

prepared to disagree with the treating physician's initial certification of medical necessity. Moreover, a finding that objective falsity is not required for FCA liability could expose providers, including SNFs, to financial liability on the basis of medical necessity. In response, providers could choose to undertake costly measures to reduce the risk of litigation.

Importantly, the First and Second Circuit Courts of Appeals–that is, those federal appeals courts with jurisdiction over New England and New York–have not yet ruled on the "objective falsity" issue. This means if the Supreme Court denies Care Alternatives' petition for review, neither the First nor the Second Circuit would be bound to accept (or reject) the objective falsity standard. As it now stands, health care providers across the country are subjected to different levels of litigation risk because of the circuit court split. For instance, while providers within the Third Circuit–New Jersey, Pennsylvania and Delaware–are now liable under the FCA for potential treble damages and penalties based on physicians' medical judgments, others, including those located in the Eleventh Circuit (Alabama, Florida and Georgia), can insist on a showing of objective falsity before being held liable.

Prominent trade organizations, including the American Medical Association, the American Health Care Association and PhRMA, support Care Alternatives in this case, and argue in amicus briefs that objective falsity should be necessary for FCA liability. The support of these organizations signals that, by and large, most health care providers believe that a physician's clinical judgment should not be the basis for FCA liability.



The outcome of "Care Alternatives" could have serious implications for health care providers, especially for SNFs and others treating vulnerable elderly patients covered by Medicare. If the Supreme Court ultimately rejects the objective falsity standard, providers are at increased risk of FCA litigation, and may need to consider undertaking protective measures to limit such risk.

Michael J. Tuteur, J.D., is a partner and health care and government enforcement defense attorney with Foley & Lardner LLP. A former federal prosecutor, Mr. Tuteur has extensive experience defending health care institutions and associated executives in criminal prosecutions, civil investigations, and in cases brought under the federal False Claims Act.

Olivia King is a health care lawyer at Foley & Lardner LLP. and counsels clients in the health care, pharmacy, telehealth and medical device industries with respect to a wide range of regulatory and compliance matters.

Lisa Noller is a trial lawyer and investigator with Foley & Lardner LLP, where she is national chair of the Government Enforcement, Compliance & White Collar Defense Practice. She has spent over 25 years investigating, litigating and trying complex criminal and civil cases, responding to government investigations, and conducting corporate internal investigations. She is renowned for her defense of health care clients in False Claims Act cases.

Things to know about Isolation, Quarantine, Skilling, COVID-19, and ICD-10

Continued from page 3

with mcc
- Respiratory infections and inflammations with cc
- Respiratory infections and inflammations without cc/mcc
- Prematurity with major problems
- Full term neonate with major problems
- HIV with major related condition with mcc
- HIV with major related condition with cc
- HIV with major related condition without cc/mcc

· The ICD-10-CM Diagnosis Code is U07.2, Virus NOT Identified
- Clinically-epidemiologically diagnosed
- Probable COVID-19
- Suspected COVID-19

· A set of additional categories has been agreed to be able to document or flag conditions that occur in the context of COVID-19.

· Both, 3 character and 4-character codes have been defined to respond to the different levels of coding depth that is in place in different countries

Personal history of COVID-19

· U08.9Personal history of COVID-19, unspecified

· This optional code is used to record an earlier episode of COVID-19, confirmed or probable that influences the person's health status, and the person no longer suffers from COVID-19. This code should not be used for primary mortality tabulation.

Post COVID-19 condition

· U09.9 Post COVID-19 condition, unspecified

· This optional code serves to allow the establishment of a link with COVID-19. This code is not to be used in cases that still are presenting COVID-19.

Multisystem inflammatory syndrome associated with COVID-19

· U10.9 Multisystem inflammatory syndrome associated with COVID-19, unspecified

· Cytokine storm

· Kawasaki-like syndrome: Temporally associated

· Pediatric Inflammatory Multisystem Syndrome (PIMS): With COVID-19

· Multisystem Inflammatory Syndrome in Children (MIS-C)

· Excludes: Mucocutaneous lymph node syndrome [Kawasaki] (M30.3)

6. HHI Recommendations

· Educate staff on Isolation versus Quarantine.

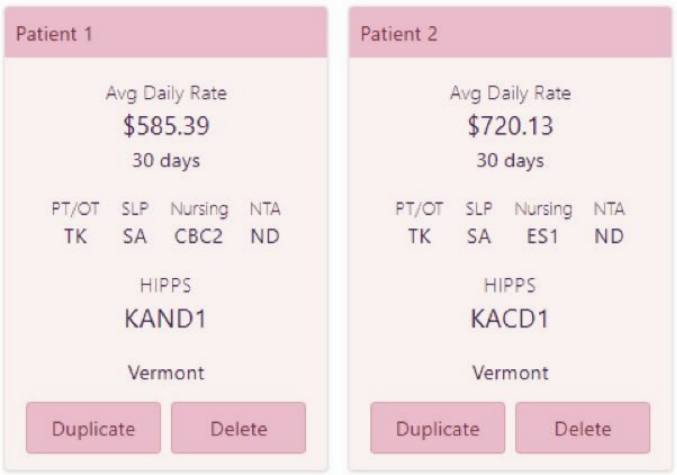
· Educate staff on Skilled Coverage Criteria.

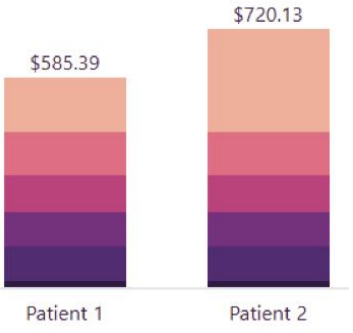
· Educate staff on ICD-10 Coding.

· Perform ongoing and retroactive medical record reviews. All patients should be reviewed immediately. It may not be possible to retroactively correct certain errors.

· Download Core Components.

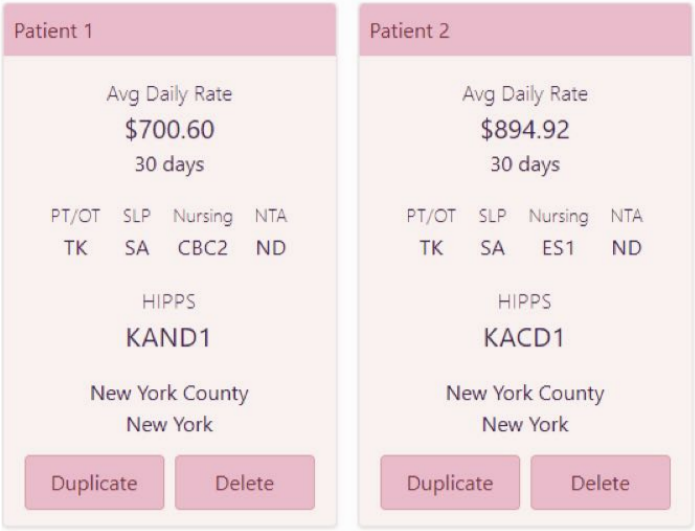
Kris Mastrangelo, OTR, MBA, NHA, is president and CEO of Harmony Healthcare International and is a nationally-recognized authority of Medicare issues. She is a regular contributer to the New England Administrator. *Contact Kris : 800-530-4413. harmony-healthcare.com*

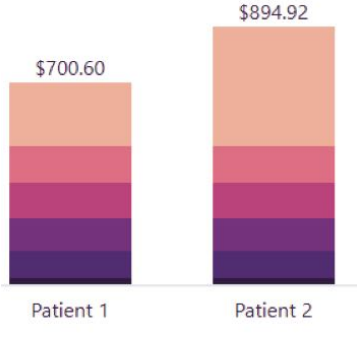




Rural, VT

$ Impact Isolation COVID-19 (VT)
= $720.13 - $585.39
= $134.74 per day x 100 days
= $13,474





Urban, NY

$ Impact Isolation COVID-19 (NY)
= $894.92 - $700.60
= $194.32 per day x 100 days
= $19,432

*Courtesy of Hopforce PDPM Calculator: https://pdpm-calc.com/

Career ladders promote recruitment and retention

Continued from page 13

private sectors have not done more to support career ladders. First, career ladders are a financial expense. Second, decision makers do not see entry-level positions as a place to make investments in staff. And there are regulatory hurdles that make the development of positions which lead from one level to the next difficult. For instance, limits on nurse delegation in many states limit the development of intermediate positions for workers who are hoping to move from CNA to LPN.

Many of us in LTC think only of CNAs when career ladders come up, but there are others who could benefit by such a strategy. In Massachusetts the Personal and Home Care Aide State Training Initiative was designed to offer generalized training programs that might help workers in home care positions to advance to home health and CNA type positions. In New Hampshire legislation to have shared roles for CNAs and HHAs builds flexibility into the system.

The Bell Policy Center's report highlights three career ladders. One moves a Personal care aide through CNA and medical assistant steps to become an LPN. Another moves a PCA through home health aide mentor through community health worker to become a health educator. A third imagines a PCA becoming a CNA, then an occupational therapy aide and finally becoming an occupational therapy assistant. The report also highlights the advantage of having stackable credentials. That is using one set of credentials to help with advancement rather than having to get course credits to become an OT aide that you already obtained to become a CNA.

Joan Hyde is a researcher and academic who owns and operates an assisted living facility in New York State. When approached for her take on career ladders her response was immediate. "The first thing we need to do is pay CNAs for their work." She said that many properly paid CNAs would not seek "higher level" work because CNA work is so gratifying. She sometimes does CNA work and immediately sensed the gratification her staff feels. This work also requires insight, sensitivity, and a high degree of understanding as well as technical expertise.

Hyde does some things with career ladders but points out that it is difficult for owners and operators because of the expense of purchasing training and having to pay for floor time that workers in training may need to attend training and study.

Len Fishman, now the director of the Gerontology Institute at UMass Boston, was able to develop a successful career ladder for entry-level workers at Hebrew Senior Living when he served as its executive director. These included workers outside the clinical realm, so maintenance workers or dietary workers may have been involved. However, like Joan he highlights the difficulty of doing these things.

Hebrew Senior Living has a very strong philanthropic base. But most home health organizations and skilled nursing facilities are not so fortunate. So once again money becomes a major issue in career ladder development. Fishman pointed out that between 1980 and 1997 the Boren Amendment provided recourse to Medicare and Medicaid providers who were not paid enough to responsibly and efficiently meet minimum standards of care. Such parties could sue the state or federal government. With its repeal there is little recourse.

So today there is not really any central depository of information about career ladders. Some facilities and organizations find ways to support career ladders and other tools for employee advancement from their budgets but there is currently little in place that is systematic or easily identified.

In "Making Care Work PAY," Christian Weller of UMass Boston and the Center for American Progress demonstrated that paying a living wage to frontline workers would be less expensive than the increase in pay itself. There would be significant operating efficiencies that would result from such a step. Further such an action would have a multiplier effect on the communities in which these people lived and worked. Public entities that pay for most long term care services still have not increased payment.

Even if entry-level workers were paid a living wage, career ladders would still have a role to play for the workers who wished to move into higher paying, more highly skilled jobs. Meanwhile, most career ladders are partial and require administrators, directors, and other managers to use their organizations' resources wisely to advance opportunities for their workers and through those workers for the organizations themselves.

K.R. Kaffenberger, PhD is an Adjunct Professor of Gerontology at UMass Boston and former Nursing Home Administrator.

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Matt Lessard, CNHA, FACHCA, District Director
mlessard@nathealthcare.com

W. Bruce Glass, FACHCA,CNHA, CALA, Editor
bruceglass@rocketmail.com

Richard E. Gamache, FACHCA Assistant Editor
rgamache1@icloud.com

Julian Rich, FACHCA, Advertising Manager
jrich44673@aol.com

Mark. A. Jacobs, FACHCA, Treasurer,
MJacobs@pinnaclecanton.com

Designed and produced by The ART of Communications
Arthur Levine
arthur@theartofcom.com • 978-927-5343