ADVISER
The magazine of LeadingAge New York | Fall 2018

LeadingAge® New York

# Emerging Models of Care

## It's A New Day

ADVISOR

LeadingAge New York

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## Feature



### Emerging Models of Care



## Departments



Our national partner, LeadingAge, is an association of 6,000 not-for-profit organizations dedicated to expanding the world of possibilities for aging. Together, we advance policies, promote practices and conduct research that supports, enables and empowers people to live fully as they age.

LeadingAge New York Mission Statement

*To create the future of aging and continuing care services in New York State.*

***Adviser*** is published twice yearly by

**LeadingAge New York**

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Latham, NY 12110-1431
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Founded in 1961, LeadingAge New York represents more than 500 not-for-profit, public and mission-driven senior care providers, including nursing homes, senior housing, adult care facilities, continuing care retirement communities, assisted living, home care and community services providers which serve approximately 500,000 people across New York each year.

## Do You Have the Capacity to Lead Change and Serve People?

According to Stephen Hawking, "Intelligence is the ability to adapt to change." Clearly, change is a constant. Everyone expects and plans for changing conditions. However, change is coming faster and from more directions than ever before. It isn't enough to intuitively adapt to change; it's more about deciding to lead, as opposed to reacting. "The entrepreneur always searches for change, responds to it and exploits it as an opportunity." This quote by business strategist Peter Drucker really speaks to the mindset of proactive change and to the success many LeadingAge New York members are having in today's turbulent environment.

Workforce is a challenge that has been reported as a priority from all parts of the aging care and services field. Finding qualified staff affects almost all parts of their workforce, from dining to nursing, and from transportation to finance. But while finding staff is a challenge, retaining staff is the driver affecting quality and the bottom line.

While finding solutions to the workforce challenges are vital, other cataclysmic changes are also in the works.

From new payment models, new quality measures and new reporting requirements to changing consumer demographics and a shift to lower cost models of care, members are literally inundated with change and opportunity. Adapt or lead?

This issue of LeadingAge New York *Adviser* highlights some emerging models resulting from the many changes at work within the system. They are the stories of taking advantage of opportunity and leading change yet, with an unyielding non-profit commitment to mission, these member stories truly start with serving people.

For specific information about the stories in this issue or to discuss future *Adviser* ideas, contact Kristen Myers at **kmyers@leadingageny.org**.

James W. Clyne Jr.
President and CEO

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# Control WC Costs Through Safety

Has your business had an increase in Workers' Compensation (WC) costs as a result of workplace accidents? If so, it's time to take a closer look at your safety program. The key to spending fewer dollars is more than just stopping a few accidents; it is having a sound safety program designed to continuously improve.


## Building a Solid OSHA Program

There are five entry-level steps you can take to have a well-rounded safety program that produces a safe work environment, achieves Occupational Safety and Health Administration (OSHA) compliance, reduces accidents and ultimately reduces workers' compensation costs.

1. Develop the various programs required by the OSHA standards.
2. Integrate those programs into daily operations.
3. Investigate all injuries and illnesses.
4. Provide training to develop safety competence in all employees.
5. Audit your programs and your work areas on a regular basis to stimulate continuous improvement.

## Develop Programs Required by OSHA Standards

Aside from being a requirement for businesses engaged in hospitality services or the entertainment and recreation industry, OSHA standards provide a good pathway to incident reductions. A hefty number of accidents stem from poorly developed, trained or implemented OSHA programs: slips or trips may come from poor housekeeping standards, burns and scalds from lax kitchen safety guidelines, and not following proper use of hazardous materials, such as cleaning products, can result in preventable illness and injury.

Many of the OSHA standards require some type of written program be developed and then communicated to all employees. Experience shows that companies with thoroughly developed, OSHA-compliant programs have fewer accidents, more productive employees and lower workers' compensation costs.

## Integrate Programs into Daily Operations

Policies alone won't get results; the program must move from paper to practice to succeed. Putting a policy into practice requires a strategic plan clearly communicated to everyone, good execution of that plan based on developed competencies and a culture that inspires and rewards people to do their best.

When developing your safety initiative, there must be an emphasis on your supervisors and helping them succeed. If your management team knows the safety program and wants to make it happen, the program succeeds; if not, it will be an endless drain on resources and energies. Providing supervisors with knowledge and skills through training is critical to the success of your safety program.

*A safety program that is compliant with OSHA standards for those in the hospitality, entertainment and recreation industry can yield significant savings by reducing injuries and illnesses, saving workers' compensation dollars over the long run.*

(See *Control WC Costs* on page 7)

# Control WC Costs ... (Continued from page 5)

A solid OSHA program integrated into the daily operation and led by competent supervisors is just the beginning. Successful safety programs focus on being proactive instead of being reactive. Accident investigations provide an excellent source of information on real or potential issues present in the workplace.

## Investigate All Injuries and Illnesses

Workers' compensation is designed to recompense employees for injuries or illnesses that arise from, or out of, the course of employment – the more injuries you have, the higher your workers' compensation costs. To reduce those costs, you must reduce your accidents. And the ability to reduce accidents is significantly enhanced when accidents are fully investigated instead of simply being reported.

Accident reports are historical records only citing facts, while accident investigations go deeper to find the root cause and make improvements. Businesses that stop rising workers' compensation costs have an effective accident investigation process that flushes out the root cause of the problem. Unless the root cause is discovered, recommendations for improvement will remain fruitless. Again, training proves beneficial because a supervisor skilled in incident analysis is a better problem solver for all types of production-related issues, not just safety.

*Experience shows that companies with thoroughly developed, OSHA-compliant programs have fewer accidents, more productive employees and lower workers' compensation costs.*

All accidents should be investigated to find out what went wrong and why. Some may suggest investigating every accident is a bit over the top and that only those that incur significant costs are worthy of scrutiny. But if your emphasis is only on those incidents that have to be recorded on the OSHA 300 log, you close your eyes to the biggest accident category: first aid-only incidents. Many companies focus on recordables or lost time accidents because of the significant costs involved, but they don't realize that the small costs and high numbers of first aid-only incidents really add up.

Statistics show that for every 100 accidents, 10 will be recordable and one a lost time incident. If you investigate only recordables or lost time accidents, 89 go unnoticed. Would you consider a quality program that allows an 89 percent failure rate successful? Reducing serious accidents means you must reduce your overall rate of all accidents – including first aid-only incidents. That only happens when every incident is fully investigated to find the root cause, and corrective actions are identified and integrated into your daily operations.

## Training and Auditing for Continuous Improvement

The final steps focus on training and auditing your program for continuous improvement. Training plays a significant role in safety and in reducing workers' compensation costs. The goal of training is to develop competent people who have the knowledge, skill and understanding to perform assigned job responsibilities. Competence, more than anything else, will improve all aspects of your business and drive down costs. Supervisors must have the knowledge and ability to integrate every safety program into their specific areas of responsibility. Every employee must know what is expected of them when it comes to implementing safe work procedures. Once the programs are developed and implemented, they must be reviewed on a regular basis to make sure they are still relevant and effective.

(See *Control WC Costs* on page 8)

# Control WC Costs ... (Continued from page 7)

This might require a significant change in how you manage your safety program, but if your workers' compensation rates are high, it may be time to make this leap.

*Businesses that stop rising workers' compensation costs have an effective accident investigation process that flushes out the root cause of the problem.*

## Tangible Benefits

1. Studies indicate there is a return on investment and that companies see direct bottom-line benefits with a properly designed, implemented and integrated safety program.
2. A competency-based safety program is compliant with OSHA requirements and therefore reduces the threat of OSHA fines.
3. A competency-based safety program lowers accidents, and fewer accidents lower workers' compensation costs. When incidents do occur, a competency-based safety program fully evaluates the issue and finds the root cause to prevent reoccurrence and provides a workplace that is free from recognized hazards.
4. A safer workplace creates better morale and improves employee retention. Auditing keeps your programs fresh and effective, and drives continuous improvement.
5. A competency-based program produces people who are fully engaged in every aspect of their job and are satisfied and fulfilled, producing high-quality goods and services.

## How Can We Assist You?

At Cool Insuring Agency, Inc., we are committed to helping you establish a strong safety program that minimizes your workers' compensation exposures. Contact us today at 800-233-0115 to learn more about our OSHA compliance and safety program resources.




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# Meet Kevin Horrigan

Associate Vice President of Public Affairs, People Inc.
Incoming President, LeadingAge New York Housing Cabinet

### What is your vision for the LeadingAge New York Housing Cabinet?

I am new, and I realize I am new. From what I have seen from members of the Cabinet and LeadingAge staff, I want to learn from them. They are extremely knowledgeable, and if I may add, everyone is so nice! I have been involved in housing on and off for 25 years or so, but not living and breathing it daily. That being said, my vision is to (1) take all of this exceptional knowledge and add to the efforts to make us a force politically; and (2) get our issues and stories out to the media, obviously with approval and involvement of the Cabinet, LeadingAge staff and Board.

### How did you develop an interest in the aging services field?

As I said, I have background in housing. I never had any experience with the issue of aging until I started at People Inc. When I started here and saw the passion my boss, now our CEO, Rhonda Frederick, had for improving the lives of our aging population, I became passionate too. As a believer in government making the lives of people better, I saw what programs like HUD 202 could do and the smiles on our tenants' faces, and I was touched.

### Did you have a mentor or a person who significantly affected the direction of your career or life?

I interned in the office of Congressmember Brian Higgins when he was a member of the City of Buffalo Common Council in the late 80s. His passion, tenacity and belief that government can make things better has always impacted me. Rhonda Frederick and her belief that not-for-profits can do the same has also motivated me. I like working for, and with, go-getters with a positive attitude.

### What do you consider your greatest accomplishment?

Obviously, none of my accomplishments are just mine. I have been part of many great things because of the people I have worked with throughout my career. I have also been part of great things because of the support of my wife and our two boys (ages 18 and 21) and the fact that we have mutual interest in politics, history, current events, sports and music. I would like to leave it there!

### What would surprise readers about you?

I don't know if there is anything, and if I shared, it wouldn't be a surprise!

### What's the best advice you ever received?

I have been given good advice over the years from my parents, mentors and friends. However, actions speak louder than words. I am more about watching and learning from people and trying to replicate my own way.

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# The PDPM Paradigm: Go Big or Go Home!

***By Hilary Forman, PT, RAC-CT, Chief Clinical Strategies Officer, HealthPRO® Heritage, Healthcare Reform Consulting, PDPM Consulting, Therapy Management***

With less than a year to go, what are you doing NOW to prep for our industry's biggest change in 20 years? HealthPRO Heritage's Chief Clinical Strategies Officer, Hilary Forman, reports from the frontline. She shares practical advice – as well as an out-of-the-box vision for ***What If?*** – related to the New World of PDPM in response to FAQs RE: PDPM.

## Q: Is PDPM good news or bad news for SNFs?

The PDPM transition is an exciting opportunity for leaders in the SNF industry to set themselves apart! Those willing to objectively evaluate imminent market shifts – and make important changes – will reap the rewards. After all, success in the post-PDPM era will be defined (finally!) by SNFs' ability to efficiently deliver on high quality, truly resident-centered care. HealthPRO Heritage recommends executing NOW on dramatic culture, process and role/responsibilities changes required to position their SNFs to succeed under PDPM.

*After all, success in the post-PDPM era will be defined (finally!) by SNFs' ability to efficiently deliver on high quality, truly resident-centered care.*

## Q: What's changing?

The tide is turning! Imagine a world where revenue isn't based on managing treatment minutes. Instead, the PDPM system will set reimbursement based on patients' clinical profiles, as captured via several documentation, coding and assessment scoring factors.

This fundamental change will turn a spotlight on all members of the IDT, but especially nursing and MDS who will be under exponential pressure to understand nuances of the new system and to document properly, communicate effectively and code correctly. And in the New World of PDPM, there are huge financial implications for anything less than thorough and flawless documentation and coding.

Now consider that this pressure on nursing is occurring amidst an almost crippling nursing shortage in New York! The fact is: Nursing is not accustomed to having their documentation support the skill that drives reimbursement; we are used to a rehab-driven reimbursement environment. Now nursing steps into the limelight.

## Q: Where does that leave therapy services?

PDPM will require the industry to redefine what to expect from therapy! Contrary to what some people may think, therapy will continue to be just as integral a player in driving and protecting revenue as ever before… but in a very different way.

Under PDPM, therapy is – in fact – in an ideal position to offer support that extends far beyond providing just traditional rehab services. After all, for the last 20 years of RUGS-IV, therapy has become very skilled at defining the processes to drive reimbursement. The tables have turned with PDPM, and nursing will rise to the occasion. But what if therapy's strengths and skills can be leveraged with nursing in support of their new roles and responsibilities?

For example, HealthPRO Heritage's approach will be to lock elbows with nursing to reduce their burden and support their new role in the driver's seat. There is an opportunity to reinforce a truly (much-needed!) collaborative approach to resident care by building/supporting clinical programs and enhancing nursing care in more skilled ways. Rehab-led process changes (to help optimize care coordination, documentation and coding practices) are also tangible examples of what HealthPRO Heritage is referring to as "Complimentary Rehab Initiatives for Nursing Counterparts."

(See *The PDPM* on page 12)

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# The PDPM... (Continued from page 11)

Frankly, therapy has always been capable of playing a more active role in case management and care coordination. Because PDPM is making this more of a priority, there is an opportunity for a new road for therapy to contribute in different, yet meaningful ways.

Long story short: Don't let the PDPM burden rest on the shoulders of your nursing staff. If responsibilities for care planning and patient management are not SHARED (as with an integrated CINC approach and IDT) the impact on nursing services/staffing, resident care and ultimately fiscal stability could be negative. Instead: focus should be on a truly collaborative effort to capture a truly accurate representation – from all members of the IDT – of care provided to ensure optimal reimbursement for your SNF. Just saying: Therapy services will be an important puzzle piece as everyone clamors to redefine what it means to succeed under PDPM.

All that being said, one fundamental tenet will still hold true. Therapy will continue to drive resident satisfaction and ensure functional/performance outcomes in competitive arenas. Remember that SNFs will still be held accountable to maintaining quality outcomes as SNFs in bundled care initiatives, and in regions with high managed care penetration like New York. Don't lose sight of how therapy is necessary to ultimately fortify fiscal stability by delivering on quality care.

## Q: What can SNFs do to prepare?

The first step to ensure positive patient outcomes, regulatory compliance and financial viability under PDPM is to perform a **RUGs-to-PDPM Crosswalk**. A **RUGs-to-PDPM Crosswalk** allows providers to see where patients (and their related patient days) land in the new PDPM groups, and thereby, estimate new Medicare A reimbursement in both aggregate and individual PDPM rate components (nursing, NTA, rehab). This information is critical for both the provider and rehab partner as PDPM care delivery models and pricing proposals are considered.

(See *The PDPM* on page 13)

## The PDPM... (Continued from page 12)

Next, we encourage SNF providers to perform a **"Deep Dive"** review of current processes & systems to address the issues that will ultimately impact reimbursement under the new system. Analyze existing communication pathways and workflow – such as admissions, ICD-10 coding, nursing documentation, case management and care transition planning, clinical pathways, finance/billing (triple check) and up/downstream partnerships – to define what changes must be made during the upcoming months to successfully transition to PDPM.

Based on the **Crosswalk** analysis and the **"Deep Dive"** review, SNFs should design their **"Strategic Work Plan"** no later than Q1-Q2 of 2019. Having this customized, well-defined roadmap will be the key to successfully navigating the transition to PDPM and not only surviving, but thriving!

*It's important for SNF providers to understand how each proposed pricing methodology supports/aligns with success drivers under PDPM.*

Additionally, it cannot be overstated how important education and training is for the interdisciplinary team. In addition to new skill sets and core competencies, the transition to PDPM will require a significant "culture change" among the SNF rank and file. This will necessitate that SNFs invest in ongoing IDT communication/training in support of embracing change. SNFs must start now and continue even beyond the transition in October 2019.

### Q: What will pricing for outsourced therapy look like under PDPM?

No doubt pricing for outsourced therapy contracts will be very different under PDPM, and many industry leaders are modeling options. It's important for SNF providers to understand how each proposed pricing methodology supports/aligns with success drivers under PDPM. Among the many pricing methods, HealthPRO Heritage is advocating for the **Risk Share Per Diem** method which best aligns incentives for both therapy provider/SNF and holds both accountable to quality patient outcomes, compliance and financial success. We encourage SNF leaders to learn more about this pricing approach where the therapy provider bills the SNF a per diem rate per PDPM therapy group. SNFs are guaranteed profit for each PDPM rehab group, and therapy partner is paid a capitated per diem rate per PDPM therapy group. We predict this model best aligns incentives to balance outcomes, utilization, costs, compliance and revenue capture.

When vetting pricing methodologies, questions worth asking your therapy provider include:

- What's the best therapy pricing method under PDPM to align incentives?
- How do I ensure my patients receive the right amount of therapy for positive outcomes?
- How much therapy staff and minutes am I able to afford based on the patients' clinical characteristics and respective PDPM group payment rates?
- How do I ensure I still meet compliance requirements under PDPM, a "managed care like" capitated system?

### Q: Additional recommendations or concluding remarks?

As an Endorsed Vendor for LeadingAge New York, HealthPRO® Heritage is proud to be among industry leaders paving the road to success under PDPM. Our experts agree: CMS' PDPM system will breathe new life into care delivery models, and we are, in fact, excited for a new world where our success will be measured by the evidence-based therapy we provide and the outcomes we achieve on behalf of our clients and patients.

(See *The PDPM* on page 14)

## The PDPM... (Continued from page 13)

We encourage SNFs to invest in a strategic work plan and be focused on the following core competencies:

- **Delivery on high quality outcomes** with proactive case management & evidence-based therapy pathways
- **Support for nursing's new role** with "Documentation ReDesign" focus
- **Plan for coding accuracy** with refined workflow, documentation & targeted training
- **Nimble care coordination** with up/downstream partners and with niche programs and clinical protocols/pathways

*Partner with a therapy provider who is accustomed to monitoring outcomes and subsequently reconciling therapy programming in order to meet/exceed LOS and functional outcome expectations.*

How to ensure flawless execution on the above core competencies will be the key to successfully navigating the transition to PDPM and not only surviving, but thriving! In a world where reimbursement will be determined by how patients are cared for, know that the ability to track and analyze outcomes will be critical. Partner with a therapy provider who is accustomed to monitoring outcomes and subsequently reconciling therapy programming in order to meet/exceed LOS and functional outcome expectations. The ability to capture outcomes and refine programming as needed is an invaluable contribution to the overall success of any skilled nursing setting and is easily driven by a savvy therapy provider.

# What You Need to Know About the Nursing Home Requirements of Participation – Phase 3

The Centers for Medicare and Medicaid Services (CMS) issued new nursing home requirements that took effect in November 2016. The changes were the first comprehensive revision to the regulations since the Omnibus Budget Reconciliation Act of 1987 (OBRA) nursing home regulations and were so broad in scope that they were to be phased in over time, with the third and final phase becoming effective Nov. 28, 2019. The new requirements relate to the increased acuity of nursing home residents, a need for better behavioral health and an emphasis on person-centered care. The changes reflect the overall CMS initiatives of reducing unnecessary hospitalizations, reducing healthcare-associated infections, reducing the use of antipsychotics and improving behavioral health.

*Whereas changes in Phase 1 and Phase 2 required some policy and procedure changes, Phase 3 poses some unique challenges from a policy, educational and structural perspective.*

While November 2019 may seem like a long way off, nursing homes should start to look at strategies to ensure that they will be fully compliant by the implementation date. Whereas changes in Phase 1 and Phase 2 required some policy and procedure changes, Phase 3 poses some unique challenges from a policy, educational and structural perspective.

### Among the major components contained in Phase 3 are:

- Ensuring that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards and practice.
- Ensuring that licensed nurses have the specific competencies and skill sets to care for residents' needs, as identified through assessments and described in the plan of care.
- Ensuring sufficient staffing to provide direct services to residents with the appropriate competencies and skill sets as part of the facility's behavioral health services.
- Ensuring an active, engaged and involved governing body.
- Ensuring an effective Quality Assurance Performance Improvement (QAPI) program that identifies and maintains performance improvement data and activities.
- Designating one or more individuals as an Infection Control Preventionist (ICP).
- Developing, implementing and maintaining an effective compliance and ethics program.
- Equipping the facility to allow residents to call for staff assistance through a communication system which relays calls directly to a staff member or a centralized work area.
- Based on the facility assessment, providing training to staff, contract staff and volunteers.
- Addressing in training the following: communication, resident rights, QAPI, infection control, compliance and ethics and behavioral health.

Many members have used LeadingAge New York ProCare to provide consulting services in developing policies and training related to Phase 1 and Phase 2.

*For Phase 3 issues and concerns, please call 518-867-8383 to make arrangements for a ProCare consultant to provide direction and guidance tailored specifically to your organization's needs.*

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# ArchCare Workforce Training Serves Industry and a Higher Calling

**TODAY** in healthcare, competitors are collaborating in ways that would have been unthinkable just a few years ago as they adapt to new payment models that encourage providers to work together to manage costs and drive better care outcomes for the populations and communities they serve.

To ArchCare, this competitive cooperation is more than just a way for providers to forge economies of scale and bring their strategic and financial interests into alignment along the continuum of care. For the non-profit continuing care system of the Archdiocese of New York, it's an opportunity to bring its resources and experience to an industry-wide problem: the critical shortage of trained and qualified long-term care workers to meet the ever-increasing demand for long-term care in New York State.

Earlier this year, the New York State Department of Health (DOH) awarded ArchCare a three-year grant to deliver a broad curriculum of training programs focused on enhancing the skills and employment and advancement opportunities of long-term care workers in New York City, Long Island and the Hudson Valley. The grant is part of DOH's Managed Long Term Care Workforce Investment Program, a $185 million statewide initiative to attract and train healthcare workers. Over the longer term, the investment in developing more highly skilled workers focused on keeping people healthier and preventing avoidable hospitalizations will pay off in lower care costs for Medicare and other payers and higher reimbursements for providers.

ArchCare has invested heavily in recent years to establish a comprehensive professional development platform for its more than 4,000 Care Members as it evolved from a provider of traditional nursing home care into a diverse system of home, community-based and institutional care. To many people, offering up these training capabilities to help workers from other home care agencies and health plans succeed may seem suspicious. ArchCare sees it differently.

"Sharing our professional development systems and experience is not only about helping our industry adapt to new payment models and a changing landscape," said Scott LaRue, ArchCare's president and chief executive officer. "Our higher calling as a Catholic ministry is to respond to the needs of society where we can serve best. Doing everything we can to ensure that all members of our communities have access to the highest quality care to us is a privilege and our responsibility."

ArchCare's initial course offerings as a state-designated Workforce Investment Organization (WIO) include training in person-centered care, health literacy, fall prevention, skin and wound care management, non-violent

archcare
Workforce Investment Organization

crisis intervention and cultural competency. Programs are held at ArchCare facilities, provider locations and other sites, and most are available on demand through ArchCare's online e-Learning system so workers can access them on their own schedules. New courses will be rolled out regularly and include certification training for Home Health Aides, Certified Nursing Assistants and Certified Case Managers.

ArchCare has also partnered with the Hartford Institute for Geriatric Nursing at New York University's Rory Meyers College of Nursing to develop additional online and classroom courses. In 2019, they look forward to introducing a first-of-its-kind geriatric nurse residency program that will provide advanced classroom and practical training for recent nurse graduates who plan to specialize in caring for older adults.

Employers may be reimbursed for the cost of replacing their workers in order to allow them to attend training. Caregivers may also be eligible for continuing education credits to help them meet state licensure requirements.

"We're repositioning long-term care workers for success in the new value-based environment," said Hugo Pizarro, ArchCare's senior vice president and chief experience officer, who leads the WIO program with an experienced team of learning and development experts. "Our goal is for 4,000 individual trainees to complete an average of 2.5 courses by the end of the first year. Three months in, we are already 40 percent of the way to that goal, and we're just picking up steam."

Find out more about ArchCare's WIO program, including course schedules and eligibility details, at *archcare.org/wio*.

*"We're repositioning long-term care workers for success in the new value-based environment," said Hugo Pizarro, ArchCare's senior vice president and chief experience officer, who leads the WIO program with an experienced team of learning and development experts. "Our goal is for 4,000 individual trainees to complete an average of 2.5 courses by the end of the first year. Three months in, we are already 40 percent of the way to that goal, and we're just picking up steam."*

Hugo Pizarro
Senior Vice President,
Chief Experience Officer

# Shooting Stars and Deadline Landmines: A Summary of the 2018 Nursing Home Compare Five-Star Quality Rating System Changes

*By Susan Chenail, RN, CCM, RAC-CT, senior quality improvement analyst*

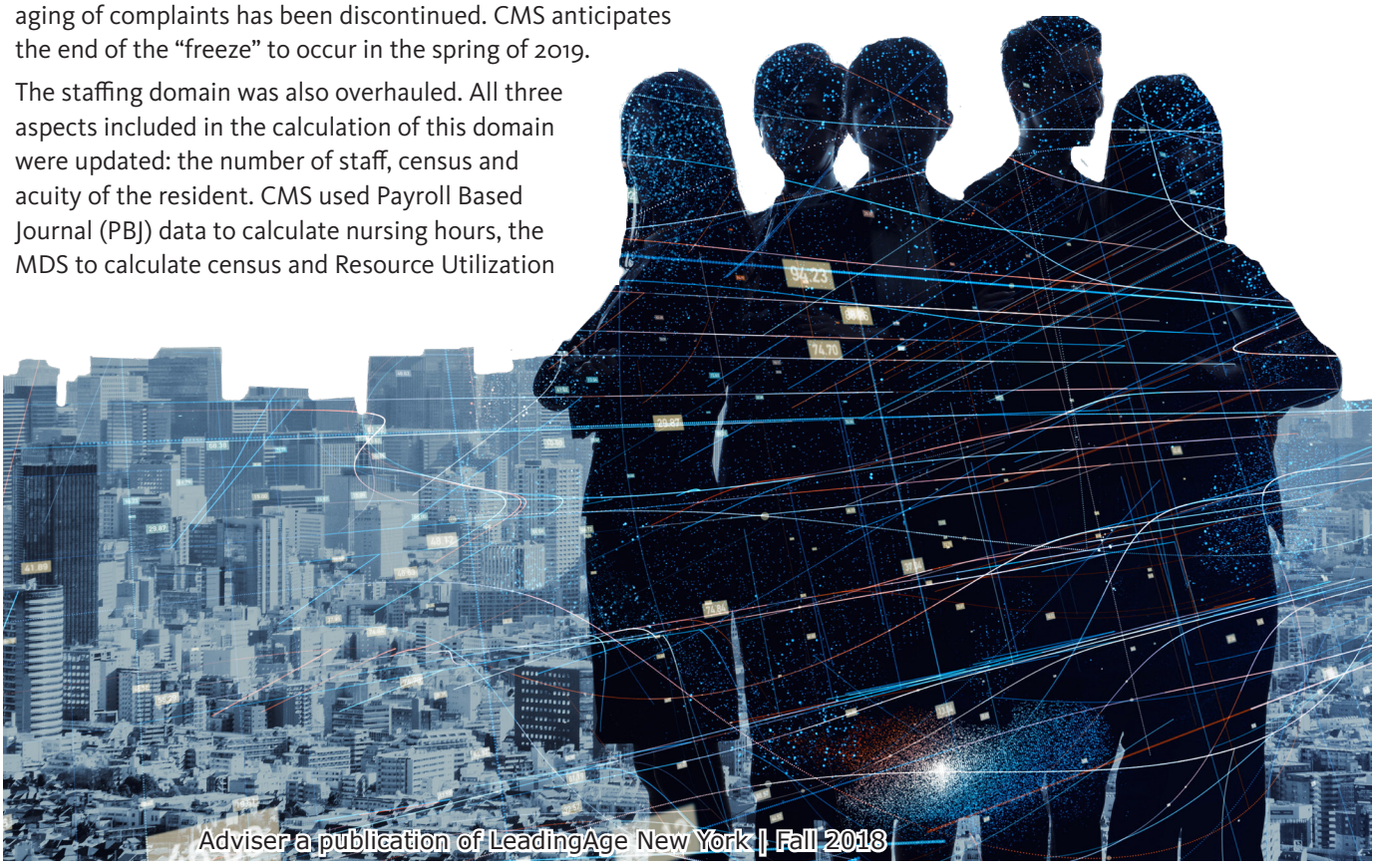
**2018** may have brought the most comprehensive revamp of the Five-Star Quality Rating System since 2015. All three domains will be updated this year. The changes include new methodologies to calculate both the health inspection and staffing domains. The quality measure domain is due for updates before the end of the year. The changes also include a new short-stay pressure ulcer quality measure that replaces the pressure ulcer measure that used the recently discontinued Minimum Data Set (MDS) items M0800 and the annual quality measure cut point adjustment.

This past spring, the methodology used to calculate the health inspection domain was clarified. Essentially, the Centers for Medicare and Medicaid Services (CMS) clarified how it was going to manage the "freeze." CMS defined the number of surveys used – the two most recent prior to Nov. 28, 2017 – and their weighting factor: 60 and 40 percent, with the most recent survey weighted heavier. It also defined the timeframes from which complaints would be used: Nov. 28, 2015 to Nov. 27, 2016 for calculation in the second most recent survey period, and Nov. 28, 2016 to Nov. 27, 2017 for calculation in the most recent survey period. The aging of complaints has been discontinued. CMS anticipates the end of the "freeze" to occur in the spring of 2019.

The staffing domain was also overhauled. All three aspects included in the calculation of this domain were updated: the number of staff, census and acuity of the resident. CMS used Payroll Based Journal (PBJ) data to calculate nursing hours, the MDS to calculate census and Resource Utilization calculate resident acuity. ***Several facilities, including those in New York,*** felt the effect of shooting stars. Some stars were lost, and some were gained, but most were unchanged.

Summer brought the one-star penalty definitions used in the staffing domain. This is a serious penalty because scoring one star in staffing reduces a facility's overall rating by one star, leaving some feeling as though they stepped on a landmine. There are three occasions that will cause a facility to score one star in the staffing domain: (1) if the facility fails to submit its PBJ data by the reporting deadline; (2) if the facility reports seven or more days with no Registered Nurse (RN) staffing; and (3) if the facility fails to respond to a staffing audit, or the results of the staffing audit identify significant discrepancies between the reported hours and the hours verified. An easy way to sidestep a deadline landmine is to submit PBJ data on time. To access a PBJ quick reference tool, ***click here***.

In October, the new MDS 3.0 v 1.16 item sets were put in use along with the updated RAI Manual. To go hand in hand with the new, revised and retired items,



CMS added and revised error messages on the Quality Improvement and Evaluation System (QIES). One of the new error codes will be an MDS Coordinator's dream come true: error code 3897. *This error code is a payment reduction warning when dashes are used* in a field that is used to calculate completeness for the Quality Reporting Program (QRP).

No matter what rules change, you can excel in quality improvement activities when you use LeadingAge New York Technology Solutions' suite of tools. Quality Metrics and the Five-Star Analysis Report are member benefit tools that facilities use to custom benchmark themselves and improve their understanding of the Five-Star Quality Rating System on Nursing Home Compare (NHC). There is one drawback to using this data in Quality Assurance Performance Improvement (QAPI) activities, however: it can be three to six months old, and in some instances, the residents included in those rates may have already been discharged from the facility. LeadingAge New York Technology Solutions' newest tool, Quality Apex, provides users with quality measure rates based on their most recently uploaded MDS. If you are interested in learning more about the products we provide, please contact Marguerite Carroll, business development liaison, LeadingAge New York, at 518-867-8383 or *mcarroll@leadingageny.org*.

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*Quality Metrics and the Five-Star Analysis Report are member benefit tools that facilities use to custom benchmark themselves and improve their understanding of the Five-Star Quality Rating System on Nursing Home Compare (NHC).*

Susan Chenail, RN, CCM, RAC-CT
senior quality improvement analyst

# Need to Know: New Long-Stay Claims-Based Hospitalization Measure Now on Nursing Home Compare

*By Susan Chenail, RN, CCM, RAC-CT, senior quality improvement analyst*

THE Centers for Medicare and Medicaid Services (CMS) believes that residents who return to the hospital frequently during their nursing home stay for unplanned reasons are less likely to be receiving proper assessments or care. In an attempt to widen those included in hospitalization measures, CMS has created a new measure that is comprised of long-stay residents titled *Number of Hospitalizations Per 1,000 Long-Stay Resident Days.*

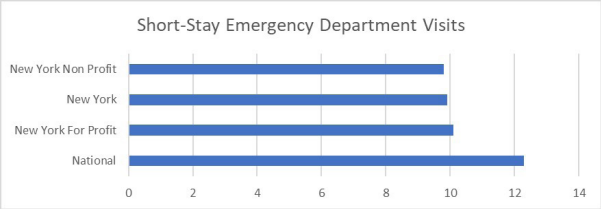
This brand-new measure is not the measures we are familiar with – for example, *Percentage of Short-Stay Residents Who Were Rehospitalized After a Nursing Home Admission* or *Short-Stay Residents Who Have Had an Outpatient Emergency Department Visit,* used to calculate the quality measure domain of the Nursing Home Compare (NHC) Five-Star Quality Rating System. This new hospitalization measure reports the ratio of unplanned hospitalizations per 1,000 long-stay resident days. Keep in mind that this is a claims-based measure which includes those residents on traditional Medicare Fee for Service (FFS), and it is also a long-stay measure which includes those residents in the facility for more than 100 days. The *Nursing Home Compare Claims-Based Quality Measure Technical Specifications September 2018* update contains more details on the new measure, including purpose, description, numerator, denominator and exclusions.

Quality Metrics was used to produce the following graphs pertaining to utilization of hospital services. The claims-based measure used in the graph titled **Short-Stay Rehospitalization** is *Percentage of Short-Stay Residents Who Were Rehospitalized After a Nursing Home Admission.* The measure used in the graph titled **Short-Stay Emergency Department Visits** is *Short-Stay Residents Who Have Had an Outpatient Emergency Department Visit.* In both measures, a lower rate is better. The data was derived from NHC reporting quarter July 2018 and the data collection period of Oct. 1, 2016 through Sept. 30, 2017. New York Non-Profits' performance on both measures was compared to that of their New York For-Profit, New York State and National peer groups.

In the first graph depicting rehospitalization, the vertical axis is the groups, and the horizontal axis is the rate. Analysis of Short-Stay Rehospitalization shows that New York Non-Profits are outperforming their peers, faring 3 percent better than New York For-Profit Nursing Homes, 5 percent better than New York State and 13 percent better than the nation.


In the second graph depicting emergency department visits, the vertical axis is the groups, and the horizontal axis is the rate. Analysis of Short-Stay Emergency Department Visits shows that

New York Non-Profits are, once again, outperforming their peers, faring 1 percent better than New York For-Profit Nursing Homes, 3 percent better than New York State and 23 percent better than the nation.




While these are short-stay measures and the new measure is long-stay, and New York Non-Profits are outperforming their peers, Non-Profits still may benefit from reviewing their policies and practices regarding transfer to the hospital, orientation, training and competencies of nursing staff, initiating programs like INTERACT and researching innovative care alternatives to improve their performance now and prepare for the possible impact of the new measure. *Number of Hospitalizations Per 1,000 Long-Stay Resident Days* was reported on NHC in October 2018 and will be used to calculate the quality measure domain of the Five-Star Quality Rating System in the spring of 2019.

*For more information on Quality Apex, please contact*

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# QUALITY APEX


## *Know Your Data...*

- *Quality Metrics is a member benefit and can be accessed at www.data.leadingageny.org.*
- *The Five-Star Analysis Report is a LeadingAge New York member benefit, and member facilities are provided with a quarterly email link to their report in January, April, July and October.*
- *Quality Apex, a Minimum Data Set (MDS)-based software analytics program, provides subscribers with their quality measure rates based on their most recent MDS upload.*

# VillageCare's *Rango*: Digital Tools to Promote Medication Adherence and Patient Engagement

**VILLAGECARE,** a New York City community-based, not-for-profit organization that serves individuals with post-acute and chronic care needs, received a Centers for Medicare and Medicaid Services (CMS) Health Care Innovation Award to develop *Rango*, a mobile application and website that was found to be effective in empowering individuals living with HIV to better manage their condition. Program enrollment began in 2015, with the pilot demonstration expiring in December 2017.

### Overview of Platform

The *Rango* program addressed many challenges that HIV/AIDS patients, providers, policymakers and other stakeholders face by increasing patient activation, improving medication compliance and reducing total cost of care for HIV positive individuals. *Rango* Services include:

- Medication and appointment reminders;
- Virtual support groups facilitated by professionals;
- Engaging online community;
- Moderated discussion boards on a variety of health and healthy living topics;
- Live chat and virtual Q&As with Health Coaches;
- Private messaging inbox;
- Text message and app notification broadcasts;
- Matching to a trained Peer Mentor;
- Article library with easy-to-understand explanations about HIV/AIDS, common comorbidities, medications and other information;
- RMDY digital therapeutics platform (personal health and wellness tracking with guided interventions); and
- Healthify social services database.

All Medicare and/or Medicaid beneficiaries residing in New York City who have been prescribed medications for HIV/AIDS were eligible to participate in the program. *Rango* services could be accessed from any computer or smartphone, with many features made available via a standard cellular device. These features are designed to be member-friendly and easily accessible. The *Rango* platform is HIPAA-compliant, and all data transmissions are encrypted.

### User Demographics

There were approximately 4,400 members enrolled in *Rango*. Of these enrollees, approximately 59 percent were male. The age distribution of enrollees was:

| Age | Percentage of Enrollees |
|---|---|
| 18-30 years | 6% |
| 31-45 years | 23% |
| 46-55 years | 41% |
| 56-64 years | 25% |
| 65+ years | 5% |

### User Activity

Medication reminders were the most utilized feature for both the app and web browser platforms. Utilization information for the most popular app and web browser features among enrollees is provided below:

| App Feature | Percentage of Enrollees Utilizing |
|---|---|
| Medication Reminders | 52% |
| Q&A Messaging | 38% |
| Library Article | 25% |
| Post in the Forum | 20% |

| Web Browser Feature | Percentage of Enrollees Utilizing |
|---|---|
| Medication Reminders | 46% |
| Post in the Forum | 37% |
| Library Article | 33% |
| Q&A Messaging | 26% |

### Health Care Expenditures

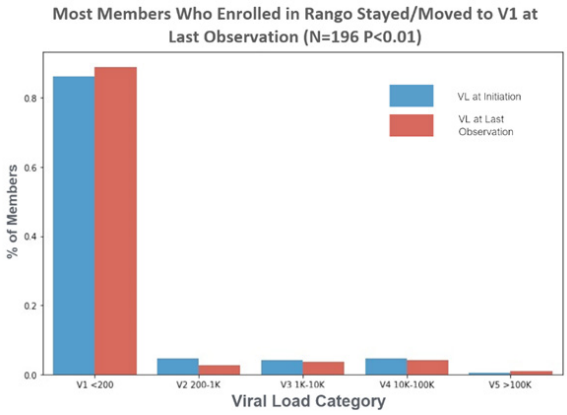
A 2017 research report conducted by the New York University (NYU) Health Evaluation & Analytics Lab (HEAL) evaluated the experience of *Rango* participants and compared six-month health expenditures data for HIV positive Medicaid-enrolled individuals who started using *Rango* in 2015 to HIV positive Medicaid-enrolled individuals not using the platform.

Overall health care service expenditures increased for the *Rango* participant group relative to the comparison group, which experienced decreases in expenditures, with a $251 increase (5 percent) in overall monthly expenditures for the *Rango* participant group. However, a closer look at specific health care service expenditures indicated a relative reduction in hospitalizations (decrease of 8 percent) and a relative increase in visits to a primary care physician (increase of 3 percent) for *Rango* participants. Furthermore, there was a 6 percent increase in the rate at which *Rango* participants filled prescriptions for any of six selected HIV drug medications compared to when they began using *Rango*, which may demonstrate the benefits of medication reminders and text messages from the program.

### HIV Outcomes

Another research study conducted by VillageCare evaluated the impact of *Rango* on viral load (VL) suppression for HIV positive individuals enrolled in the program. The study found that 94 percent

of *Rango* participants who had suppressed VL at *Rango* initiation remained in the same VL range at last observation, a relationship that was statistically significant (P < 0.01). These results suggest that *Rango* is a potentially effective technology platform for helping individuals maintain their VL suppression.




**Future Outlook**

Positive user experience and preliminary research results demonstrating the effects of the *Rango* platform on health care utilization, expenditures and HIV outcomes indicate that *Rango* had an overall positive effect on both the lives of program participants and the health care system in general.

Over time, *Rango* may be tailored for plans and providers trying to meet the needs of various patient populations, along with various chronic illness diagnoses. VillageCare is proud of *Rango's* success in helping individuals to better manage their HIV and continues to explore innovative ways to utilize this effective self-management tool to help individuals fighting HIV or other chronic conditions.

VILLAGECARE

## *Participant Experience*

***Qualitative data on the participant experience using the Rango platform is overall very positive. While active, the application maintained a 4.5 Star average review on the Google Play App Store and was regarded as "a fun and convenient resource." Rango testimonials included the following:***

> ***"It is wonderful to have a place or people to converse with and feel comfortable. When I was diagnosed in 2003 I felt alone. I had no one other than my husband...Today life is better."***

> ***"Thanks to Rango for keeping me on track, I'm forever grateful for having a support system."***

> ***"I love this site. It's very helpful. I'm glad I have the opportunity to communicate with people dealing with the same issues. Thumbs up."***

# Navigating Challenge and Change: Two Lessons in Leadership

**WE** asked two alumni of the LeadingAge New York IGNITE Leadership Academy to share their leadership experiences with us as they relate to the ever-changing, ever-challenging field of long term care. The first is a story of resident engagement, a key area of focus for success highlighted in ***Resident Engagement: A Priority for Tomorrow's Life Plan Community*** by Holleran. The second story is about leading through change—which seems to be the only constant in our field these days. The stories from these rising stars will surely resonate with other long term care and aging services professionals, and their learning may offer a spark of an idea of inspiration.

*Jessica Florio, LNHA, MHA, is the administrator of Wesley Health Care Center, a 342-bed skilled nursing facility located in Saratoga Springs, NY. She is a graduate of the IGNITE Leadership Academy 2017-18 class.*

**Your Action Learning Project of creating a *Resident Leadership Committee* focused on resident engagement, which is a critical indicator for success in long term care. How have you and your organization been impacted by the project thus far?**

Wesley Health Care Center places great value on the engagement of its residents to enhance their quality of life and achieve meaningful resident participation within our community. To do this, our Resident Council has been restructured to enhance resident engagement and identify leadership skills among participating residents. We work with the council in an interactive manner to identify challenges and problem-solve together with our interdisciplinary team. Residents in the group who had interest in leading and being a voice for their building were approached for additional leadership responsibilities, and these residents meet regularly with administration. These resident leaders can participate on performance improvement project teams to provide new perspectives and solutions on customer service challenges and process breakdown. Resident members of the committee have become trusted partners in offering creative operational, customer service and individualized initiatives within our campus. The ultimate goal is for us to implement resident-driven solutions that best fit their wants and needs.

**How did the IGNITE Leadership Academy shape you as a leader in this effort?**

As a graduate of the IGNITE Leadership Academy, my point of view has shifted as a leader. I have a greater appreciation of the importance of engaging residents in the decision-making process. These residents have offered great insight into the phrase 'do nothing about me without me.' We look to the interdisciplinary team to solve the many challenges that arise in our field. To truly understand the effect that the problem has on resident life and develop a promising resolution, a leader must step back and allow the residents to lead the way.

*Michele Gordon, RN, LNHA, is the administrator of UHS Senior Living at Ideal in Endicott, NY. She is a graduate of the IGNITE Leadership Academy 2017-18 class.*

**Change is a constant in long term care and aging services today. Successfully leading your staff through major changes can be difficult. How did the IGNITE Leadership Academy help you navigate change in your organization?**

Healthcare is a dynamic field – particularly long term care, which is changing faster than ever. Our regulatory environment, payment

methodologies and workforce challenges are just a few major moving parts. Managing any change, even a minor one, throughout an organization can be difficult. Imagine now, in the midst of all of these challenges, that you've been notified of something major – like a change in ownership! That is the change that we are dealing with in my organization. The timing of this announcement and the subsequent challenges for me and my team coincided with my IGNITE Leadership Academy experience, which provided me with an unexpected support during one of the most challenging times of my career.

One of the first tasks that a leader must accomplish in order to lead a team through change is to decide – decide your own path, your own journey and contemplate a direction for the team. Just like a captain on a ship using a compass, navigating any change can be accomplished if the leader has and uses the right tools. Relationships are important as well and they must be built before you are in a crisis. Relationships forged through camaraderie in advance of our struggle have helped to create an armor of protection for the leadership team against the stressors and struggles we encounter through the journey of change.

Through the IGNITE Leadership Academy, I developed and refined several skills, including communication, team building and using my defining moments to help form my future. Exercising and sharing those skills are proving to be building blocks to our organization's strength and perseverance. Fear of the unknown has been our worst enemy and we have navigated that fear as a team through openness, active listening, connectivity and building on previous experiences and successes – all skills I have learned at IGNITE and shared with my team.

LeadingAge New York

IGNITE YOUR FLAME Leadership Academy

***The LeadingAge New York IGNITE Leadership Academy is a professional development program designed to facilitate the development and growth of senior living leaders in the state. The academy focuses on internal and external relationship building, the sharing of best practices and a passion for continuous learning. It is exclusively for members of LeadingAge New York and our affiliates.***

***For more information on IGNITE Leadership Academy, please contact***

Diane Darbyshire, facilitator and senior policy analyst, LeadingAge New York, at
518-867-8383 or ddarbyshire@leadingageny.org

Leadership Academy facilitators, coaches and class of 2018

# Seniors Thrive in ArchCare Program Where Time Is Money

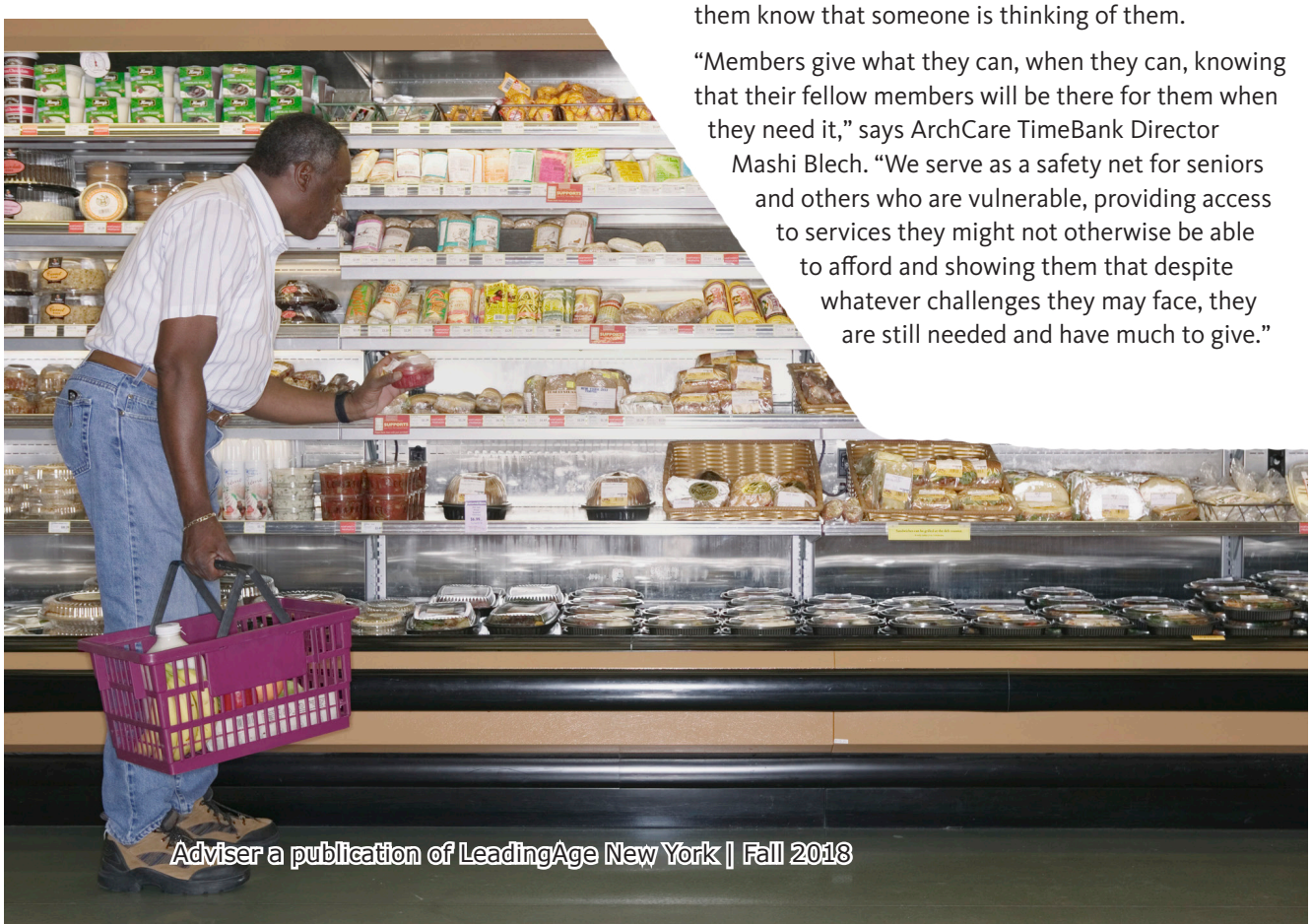
**WITH** its unusually high rate of senior poverty and aging immigrant population, New York City urgently needs interventions to engage socially isolated elders in their communities and help them live active, meaningful lives as they age in place. The dearth of assistance for those who can no longer participate in community-based programs takes an especially heavy toll in neighborhoods like the South Bronx and Lower East Side, where as many as one in three seniors lives alone. For them, social isolation and loneliness cause more than unhappiness. Seniors who live in isolation are at greater risk of cognitive decline, depression, malnutrition and other health problems. They are also more likely to delay seeking medical care, which inevitably leads to higher rates of avoidable hospitalizations and nursing home placements.

Since 2014, the healthcare system of the Archdiocese of New York, known as ArchCare, has employed a novel form of banking to draw thousands of at-risk seniors out of isolation, connect them with needed supports and renew their sense of dignity and purpose – all at no monetary cost. Known as "timebanking," the pioneering approach has proven remarkably effective in helping seniors feel less isolated, more connected to their community and more comfortable seeking and accepting the help they need.

The ArchCare TimeBank, which today has nearly 2,000 members across the city, is founded on an innovative service exchange model that connects people who need assistance with volunteers in their neighborhoods who have the time, energy and skills to help them. TimeBank is no garden-variety volunteer program, however. It is an alternative economy in which time replaces currency and all citizens have the opportunity both to give and receive services. Every hour of service a TimeBank member contributes earns an hour of credit that can be redeemed for help at any time from any other member. In the TimeBank economy, all hours have equal value regardless of the services being exchanged.

For seniors, TimeBank is a gateway to the support they need to continue living safely in the community. Their fellow members provide companionship; pick up prescriptions; escort neighbors to doctor visits; help with shopping, cooking and light housekeeping; and share language, crafts and computer skills. Even the frail can contribute something in return, whether it's knitting blankets or making crafts, writing birthday and get-well cards or simply calling other members to let them know that someone is thinking of them.

"Members give what they can, when they can, knowing that their fellow members will be there for them when they need it," says ArchCare TimeBank Director Mashi Blech. "We serve as a safety net for seniors and others who are vulnerable, providing access to services they might not otherwise be able to afford and showing them that despite whatever challenges they may face, they are still needed and have much to give."



archcare
Workforce Investment Organization

The goal is to foster a culture of reciprocity that brings people of all ages, backgrounds and financial means together to support one another. Seniors are much more comfortable asking for and accepting help when they know they can "pay it forward" by helping someone else, Blech says. This may also increase the likelihood that they will ask for medical help when they need it instead of allowing chronic health problems to go untreated, potentially heading off preventable ER visits and hospitalizations.

TimeBank also provides a powerful support network for seniors enrolled in ArchCare's Program of All-Inclusive Care for the Elderly (PACE) and Managed Long Term Care (MLTC) plan. By embedding TimeBank into its health plans, ArchCare is able to measure how reduced isolation and increased social engagement affect seniors' emotional and physical well-being and influence specific health outcomes over time.

The results speak for themselves. Of PACE and MLTC participants who engage regularly with other TimeBank members by phone or in person for six months, 77 percent say their mental health has improved since they joined the program and 44 percent report better physical health. Four out of five seniors say they feel less alone since joining TimeBank, 63 percent say their quality of life has improved and 29 percent report having more friends.

TimeBank doesn't just enable 91-year-old Edith to continue living in the apartment and community she loves. The memoir-writing workshops she leads allow her to give something very personal in return. For Edith, the joy she hears in her students' voices as they share their life stories with the group is the most meaningful gift she could ever receive.

Learn more about ArchCare TimeBank at **archcare.org/community-resources/timebank**

***Clarita has always suffered the lifelong stigma of being a little person. Then, she was hit by a cab, leaving her in a wheelchair and unable to leave her home without assistance. After joining the ArchCare TimeBank, Clarita was matched with Carmen, who helps her get out of her house and where she needs to go. In return, Clarita tutors Carmen's two young daughters, renewing her sense of purpose in life and alleviating her loneliness.***

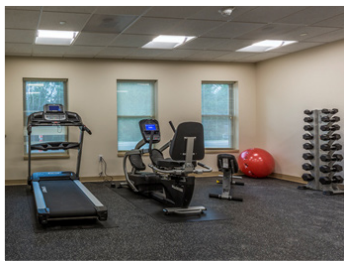
# No Place Like Home: Christopher Community and St. Camillus' New Harborbrook Apartments Help Seniors Age in Place with Supportive Services

*By Jeff Diamond*


For many adults, the well-known expression "there's no place like home" takes on a particularly special significance as they enter their senior years. Aging in place and remaining active in the community has become a common goal and one that has reshaped the ways that providers, advocates and policymakers think and talk about aging services. When a senior's home no longer accommodates his or her physical needs, however, this goal can become very difficult to achieve.

This dilemma was on the minds of the leadership of Christopher Community, Inc. and The Centers at St. Camillus in 2013, when the organizations began discussing ways to expand their services into the Syracuse community. Staff recognized that many older adults who were not physically ill or did not have long term diagnoses often ended up in skilled nursing facilities (SNFs) because they lacked the supports and services to live independently. With the discovery that St. Camillus owned most of the large parcel of open land directly adjacent to its campus, the conversation turned to designing and building permanent supportive housing that could accommodate those changing needs.

The result of this dialogue between Christopher Community and St. Camillus is the new Harborbrook Apartments, a two-story building offering 60 one-bedroom independent living units and supportive services for a subset of residents that connect them to governmental and community resources, increase their self-management of personal and instrumental activities of daily living and provide assistance for personal care when formal services are not scheduled. Twenty of the 60 units are wheelchair accessible, and the other 40 are fully adaptable (equipped with cabinets that can be reconfigured if a resident suddenly requires a wheelchair and needs the ability to roll under the kitchen sink, for example). There are no bathtubs in the building; all 60 of the bathrooms include roll-in showers, with grab bars in place. Additional special design features such as lift systems are incorporated into units reserved for individuals with a severe physical disability or traumatic brain injury to enable easy wheelchair transfers in the absence of an aide. In addition to the units, Harborbrook residents have access to a community room and a wellness room with fitness equipment, suitable for exercise classes, fall prevention workshops and other wellness activities.



St. Camillus, with the assistance of a $2.5 million grant through the Governor's Empire State Supportive Housing Initiative (ESSHI), is providing programs and services to 20 Department of Health (DOH), Medicaid Redesign Team (MRT) residents at Harborbrook who are frail elderly and individuals with a physical disability or chronic condition who are currently in or at risk of placement in a SNF and can safely live in the community. Funded supports include a part-time registered nurse; a service coordinator, responsible for ensuring that any community needs required by residents are organized and coordinated; independent living skills trainers, who, on the recommendation of the service coordinator, will work with residents who require assistance with grocery shopping, bill management and other higher-level activities of daily living; and 24-hour emergency attendants, responsible for addressing any emergent health needs that occur outside of the time that residents' aides or assistants are present. Also included as part of the ESSHI grant is funding for residents' security deposits, their first month's rent, a portion of their utilities and further rent subsidies depending on their level of income. Outside of ESSHI, St. Camillus is also offering residents rehabilitation services and home health care through its home care agency.

For the staff at St. Camillus and Christopher Community, the Harborbrook Apartments represent an important step toward addressing the emerging health needs of Syracuse's vulnerable populations and helping them age in place with the highest quality of life possible. Harborbrook residents, for their part, are just as enthusiastic about being able to return to an independent living environment. With special design features that accommodate their changing needs and services that bridge them to essential supports within the community, Harborbrook is bringing the goal of aging in place well within reach for many seniors — and new truth to the idea that "there's no place like home."

For more information about the Harborbrook Apartments, please contact Christopher Community at 315-424-1821 or visit *www.christopher-community.*org.
You may also contact The Home Care Center at St. Camillus at 315-488-2831 or visit *www.st-camillus.org/programs-services/home-care.*

*With special design features that accommodate their changing needs and services that bridge them to essential supports within the community, Harborbrook is bringing the goal of aging in place well within reach for many seniors — and new truth to the idea that "there's no place like home."*

# VillageCareMAX: Road to Value-Based Payments

**VILLAGECARE** began in 1977 as a project by community volunteers to rescue and reorganize a for-profit nursing home slated for closure. It has developed into a much larger organization that provides post-acute care, community-based services and managed long term care. The organization focused on the geriatric population until the 1980s, when it found itself in the epicenter of the burgeoning AIDS crisis. As a not-for-profit health care organization, the Board and leadership of VillageCare felt it was critical for the organization to develop programs to serve those with HIV and AIDS.

With significant progress made in the treatment and prevention of HIV/AIDS, VillageCare shifted its focus by developing additional services to support the frail and chronically ill living in New York City. VillageCare opened a post-acute nursing facility, a Medicaid Assisted Living Program (ALP) and several community programs. Most notably, in 2012, VillageCare established a managed long term care plan, VillageCareMAX MLTC (VCM), and in 2017 added two dual eligible Medicare-Medicaid plans: a dual Special Needs Plan (DSNP) and a Medicaid Advantage Plus (MAP).

Today, VillageCare is a community-based nonprofit health care organization that serves over 25,000 people, with over 11,000 members in health plans operated by VillageCareMAX.

**Experience with Innovation and Risk**

VillageCare has a long history of being on the leading edge.

VillageCare Rehabilitation and Nursing Center (VCRN) undertook a full risk arrangement back in 2015, when the nursing facility joined the Centers for Medicare and Medicaid Services (CMS) Bundled Payments for Care Improvement (BPCI) initiative as a Model 3 Episode Initiator. This arrangement, which recently concluded due to CMS changes, set a target price based on historical data for an episode of care. As an example, rehabilitation for a total hip replacement lasting 30, 60 or 90 days would have a target price that included total cost of care for an individual with Medicare Fee for Service (FFS) for a certain diagnosis. This price included the cost of care for all days in skilled nursing care as well as home care, durable medical equipment, physician services, diagnostic testing and the cost of hospital stay, if the individual was re-hospitalized. CMS compared the cost of a current episode in the facility to the target price. If the cost was less than the target price, the facility retained the savings. If the cost was greater, however, the facility would owe the difference to CMS. It was a true Level III risk arrangement – weighing potential upside to potential downside. VCRN retains a net savings from participating in this program to date.

In addition to the BPCI program, VCRN is at risk for certain managed care payors through case rates which allow for savings if average length of stay is below that implied by the case rates. As evidenced at VCRN, VillageCare has a long history of pursuing innovative payment models.

**Applying Experience and Knowledge to Managed Care Value-Based Payments**

Through knowledge gained in the organization of risk arrangement at VCRN, VillageCareMAX embraced the New York State Department of Health (DOH) Value-Based Payments (VBP) roadmap early on by training leaders, managers and staff in the principles behind the roadmap. Additionally, the Plan established an internal VBP Workgroup when Value-Based Payments became mandated for all MLTCs in the fall of 2017.

The workgroup set out to develop a VBP strategy that included:

- Limiting contract variation;
- Choosing actionable quality measures;
- Enabling success through data;
- Provider Scorecard on Quality Metrics;
- Gaps in Care reporting;
- Measuring performance against plan goals; and
- Customizing provider outreach.

VillageCareMAX identified the need to leverage key relationships with Licensed Home Care Services Agencies (LHCSAs) in the Plan's network to ensure success while recognizing that significant consolidation of agencies would occur in the process.

A team comprised of provider relations, business development, strategy, data/analytics, quality and plan operations conducted provider outreach to select agencies for purposes of gauging appropriate agencies for the Plan to partner with in 2018. Criteria set for LHCSAs to participate included:

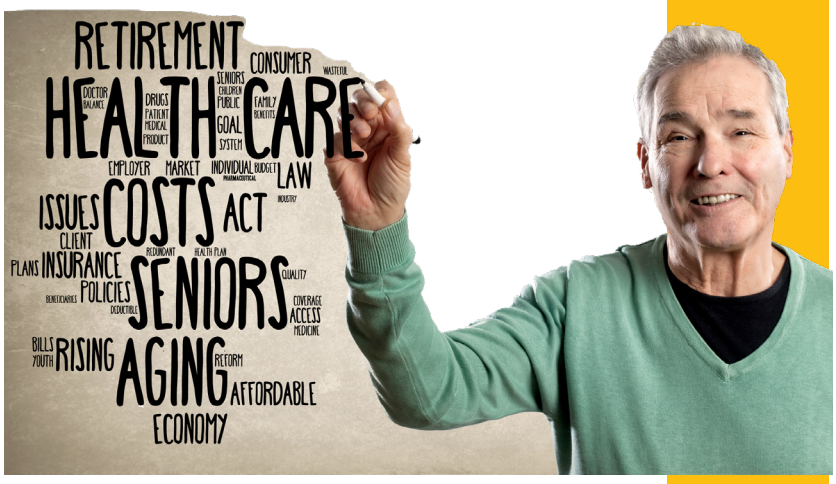
- Willingness to collaborate;
- Infrastructure for training;
- Understanding and willingness to work toward performance measures;
- Significant level of enrollment;
- Size and fiscal health of agency;
- Geographic coverage; and
- Cultural and language competencies.

**MLTC Total Cost of Care Pilot with DOH**

An exciting element in the DOH roadmap was the potential for pilot projects for the Total Cost of Care for the MLTC population. The goal for these pilots was to work toward integration and reduce the rate of decline for MLTC members. VillageCareMAX spent several months exploring options to work with Medicare contractors and ultimately looked to contract with DOH on Medicaid FFS members (approximately 15 percent of membership) of the MLTC.

*Continued on page 33*

VILLAGECARE




*Today, VillageCare is a community-based nonprofit health care organization that serves over 25,000 people, with over 11,000 members in health plans operated by VillageCareMAX.*

*As an enterprise, VillageCare and its Board of Directors are committed to its not-for-profit mission and maintaining its tradition of innovation and leadership. The organization is focused on improving access to data and insights provided by analytics to accomplish all goals.*

# VillageCareMAX: Road to Value-Based Payments *Continued from page 32*

Emerging Models of Care

Key assumptions on this population included the following:

- The community-based MLTC population is a chronically ill population at risk of functional decline, potentially avoidable hospitalizations and long term nursing facility placement.
- MLTC Plans bear the risk of the functional decline and long term nursing home placement, while Medicaid FFS primarily bears the risk of potentially avoidable hospitalizations.
- MLTC spending per member per month (PMPM), Personal Care Assistant (PCA) hours and Nursing Facility Level of Care (NFLOC) scores all indicate a 3 percent growth on average for persons with two consecutive assessments 180 days apart, with significant variation.

In 2017, VillageCareMAX reached an agreement to pursue this approach using three years of historical Medicaid FFS data to create a benchmark for Medicaid FFS spending on hospital and physician costs. VillageCareMAX was formally awarded a VBP pilot project in May of 2018. The care model envisions working with LHCSAs and using technology in the home, coupled with enhanced care management to improve member outcomes and reduce hospitalizations and concomitant further functional decline.

**Expansion to an Integrated Product (MAP) Level 2 VBP Arrangement**

Over the last several months, VillageCareMAX's Medicare Advantage Plans have focused on expanding their own proprietary physician and hospital networks that will be well-suited to the dual-eligible population that the plans serve. As part of that effort, VillageCareMAX began to work with several physician groups interested in a risk-based arrangement to jointly manage both the Medicare and Medicaid portions of the spend for the Plan's members. VillageCareMAX is working closely with these providers to design the care model, establish communication protocols, create benchmarks and craft a financial arrangement to ensure improved member outcomes on the road to shared savings on total cost of care.

There are many factors to consider when modeling for VBP. Such factors include costs associated with provider contracting, medical management, legal, technology and more. It is also important to work closely with provider partners to fully understand the needs of the member and the most efficient methods of care and reporting. VillageCareMAX continues to explore pathways to building the most comprehensive provider network that aligns with organizational goals for care and achieves the highest possible outcomes.

**Future Work on Value-Based Payments**

As an enterprise, VillageCare and its Board of Directors are committed to its not-for-profit mission and maintaining its tradition of innovation and leadership. The organization is focused on improving access to data and insights provided by analytics to accomplish all goals.

VillageCareMAX is making significant investments in key areas such as enhancing member experience, improving provider information, obtaining data from the member's home and collaborating with providers in deep and meaningful ways. All of these investments lead to a single goal: to improve the quality of care provided to all VillageCareMAX members.

# Good Shepherd/Chase Acquisition Demonstrates the Power of Partnership

*By Jeff Diamond*

It's no secret that not-for-profit skilled nursing facilities (SNFs) across New York are facing unprecedented challenges. Growing financial and regulatory pressures, workforce shortages and shifting demographics have left many providers with little recourse but to make difficult decisions about their futures. Some, however, have managed to weather the storm in a different way: by partnering with other not-for-profits in their communities.

What began as a casual conversation at a LeadingAge New York function led to the formation of one such partnership between Chase Memorial Nursing Home, an 80-bed facility in New Berlin, and Good Shepherd Communities, a not-for-profit provider of long term care services in the greater Binghamton area. Prior to the initial dialogue, Chase had been considering selling to a for-profit due to the challenges it experienced as a freestanding facility in rural New Berlin. With the nearest long term care provider located approximately 15 miles west, it had come to play an essential role as the community's only SNF. Further complicating the decision was the fact that Chase, in addition to skilled nursing, provided several services to the area indirectly, including low-income senior housing through a partnership with another not-for-profit, rental space for the local Head Start program and space for a day treatment program for adults with developmental disabilities. Maintaining those services within the community was a priority for Chase and what ultimately led its leadership to contact Good Shepherd to express interest in an acquisition.

Good Shepherd was equally interested in helping Chase remain a not-for-profit and preserve its services in New Berlin. It also, however, recognized the importance of exercising due diligence to protect its existing entities, Good Shepherd Fairview Home and Good Shepherd Village at Endwell. The organization retained The Bonadio Group to study the financial feasibility of the acquisition, developed protections to insulate each entity from the liabilities of the others and evaluated how the success or failure of the acquisition would impact its reputation in the community. Ultimately, after careful deliberation, the boards of both organizations voted to move the acquisition forward.

GOOD SHEPHERD Communities AT BINGHAMTON

***For Good Shepherd and Chase, the success of the acquisition demonstrates the power of partnership for providers navigating a changing health care landscape.***

The benefits of the acquisition, which has allowed Good Shepherd and Chase to retain their individual identities, have been significant. As started under a management services agreement implemented prior to the acquisition, Good Shepherd has taken over many of Chase's back office functions including: payroll, human resources, Medicare, Medicaid, third-party and private billing. Further savings for Chase have come from Good Shepherd instituting its vendors and covering all acquisition transition costs with the help of a $1 million Vital Access Provider (VAP) grant, which also funded staff training from LeadingAge New York ProCare. Good Shepherd has experienced the positive impacts as well, observing little to no increase in management costs and benefiting from a management fee from Chase that reduces the amounts charged to its other two entities.

For Good Shepherd and Chase, the success of the acquisition demonstrates the power of partnership for providers navigating a changing health care landscape. From implementing a management services agreement to pursuing a full acquisition, there are numerous ways that not-for-profit SNFs can join forces with other organizations in their communities to weather the storm and continue fulfilling their missions.

# A Virtual Concierge at The New Jewish Home

AT Sarah Neuman, The New Jewish Home's Westchester campus, post-acute patients and residents are utilizing Virtual Concierge, voice-enabled Amazon Echo Show devices customized for older adults, to achieve greater independence and autonomy. The Connect the Dots program behind Virtual Concierge was developed by Soundmind Intelligence and is the first of its kind to be used in a skilled nursing facility.

Synced to the campus calendar of events and meal plans, the devices, which answer to "Alexa" and respond to voice commands, are easy to use. Unlike computers or tablets, they don't require logging in, remembering passwords or typing on a keypad. For older adult clients with limited mobility, dexterity problems or impaired vision, Virtual Concierge has been especially helpful. A rehab patient with vision impairment explained that trying to find out the time when he woke up in the middle of the night used to be a challenge, but now he simply asks, "Alexa, what time is it?"

After a brief program pilot in April, Virtual Concierge has now expanded throughout Jewish Home's Westchester campus. More than 70 Amazon Echo Shows are currently operational, including one in each post-acute rehab room, and several long-term care residents also have the device set up in their rooms. Additionally, Virtual Concierge is utilized to enhance therapeutic recreation activities in communal areas of the long term care floors and communities. In response to the positive reviews from staff and clients, Jewish Home expects to have 100 devices operationalized by the end of the year.

Although many rehab clients and residents had initial reservations about using Virtual Concierge, once they learned how easy to use it was, they were hooked. A former post-acute rehab client, Enrico Corrado, said, "I didn't think I would use it at all, but after the staff showed me how it worked, I was asking Alexa questions every single day."

For many older adults, being able to easily connect to their personalized care team, find out what's on the menu and enjoy music of their choice ("Sinatra" remains one of the most frequent requests) is empowering.

Virtual Concierge also helps New Jewish Home clients remain connected to their interests and communities. Mr. Corrado, an avid football fan, was concerned that his rehab stay would make it difficult for him to keep up with his teams, but thanks to Virtual Concierge, "I didn't miss a game."

He explained, "What I liked most about the device was that it tells you everything you want to know in seconds. It was so easy and convenient. Before I was discharged, I made sure to buy one for myself so I could continue using it at home."

As a health care system that embraces person-directed care, Virtual Concierge helps The New Jewish Home staff to deeply know the older adults in their care by providing real-time insight into their needs and interests. Patterns of use can be studied to reveal preferences and engagement activities. Weekly meetings between Soundmind and New Jewish Home staff promote open conversations about how they can continuously refine the

services of Virtual Concierge based on the suggestions shared by older adults at Sarah Neuman. In response to requests to be able to play specific songs, Soundmind will be incorporating a music streaming service. Jewish Home's therapeutic recreation leaders mentioned that clients would like Alexa to recite spiritual readings when prompted, so the organizations are working together to meet their request.

In addition to personalizing Virtual Concierge based on client preferences, Jewish Home is exploring ways the technology can be used to complement and strengthen existing programs, especially those that help improve the quality of life for older adults with dementia. As the first skilled nursing facility to collaborate with Inspired Memory Care, Jewish Home's Westchester campus is providing rehab patients with memory impairments and their caregivers a strengths-based approach to meeting the unique needs of this population. Sarah Neuman also recently earned Comfort Matters® accreditation, a program that implements evidence-based best practices in dementia care that emphasize residents' comfort.

A comprehensive health care system for older adults, The New Jewish Home is beginning to examine how it can expand Virtual Concierge so that clients of its community-based programs can also benefit from this personalized technology.

"Our Virtual Concierge program has been incredibly successful for our clients and staff at Jewish Home," said Sandra Mundy, Administrator of The New Jewish Home's Westchester campus. "As a system that is focused on empowering older adults to enhance purpose and well-being, we look forward to continuing to embrace technology to engage, inform and meet the needs of our clients."

THE NEW JEWISH HOME
Sarah Neuman


*Virtual Concierge in a Resident's Room*

***For many older adults, being able to easily connect to their personalized care team, find out what's on the menu and enjoy music of their choice ("Sinatra" remains one of the most frequent requests) is empowering.***

# Medication Certified Aides in Skilled Nursing Facilities: An Innovation Whose Time Has Come

**ONE** of the **New York State Department of Health's (DOH) stated Strategic Priorities** is to strengthen its capacity to achieve its goals – through improving organizational responsiveness to the needs of the public, ensuring the delivery of high quality products and services and improving the performance of its programs and systems through employee development, as well as organizational learning.

We all recognize the many challenges in health care. We talk about innovation. We talk about transformation. Unfortunately, many roadblocks and old paradigms stand in the way of realizing our goals and true potential to do good.

Utilizing Medication Certified Aides (MCAs) in skilled nursing facilities (SNFs) is one innovation whose time has come. At the forefront of advocating for this practice in New York State has been United Helpers in St. Lawrence County, an organization whose leadership has been working for years to get a demonstration project assessing the value of utilizing MCAs in SNFs approved. New York State approved an MCA training course decades ago, and several successful State programs currently allow MCAs – programs that provide far less Registered Nurse (RN) supervision than a SNF is able to provide.

In the face of a state and national nursing crisis that experts agree is only going to get worse and an industry that struggles to recruit and retain employees, why not try something that over 30 states are already doing successfully? Think of the possibilities: career opportunities and wage increases for our best CNAs, stabilized staffing and nurses available to do nursing! There are over 630 SNFs in New York State. Allowing each of them to conservatively utilize five MCAs would free up over 3,000 badly needed nurses – going a long way toward alleviating their workforce challenges, improving the quality of care provided and even assisting DOH in fulfilling its Strategic Priorities.

United Helpers
Since 1898

*There are over 630 SNFs in New York State. Allowing each of them to conservatively utilize five MCAs would free up over 3,000 badly needed nurses...*

# St. Ann's New Adult Day Program at Durand Senior Apartments Benefits "The Most Important People on Earth"

*By Jeff Diamond*

As seniors across New York and the nation continue to pursue ways to age in place, one collaboration between St. Ann's Community and Providence Housing Development Corporation is bringing a new approach to individuals in the greater Rochester area: affordable housing and adult day health services under one roof.

Durand Senior Apartments, a new development by Providence Housing for seniors aged 55 and older, will feature 70 one- and two-bedroom apartments, meeting a critical need for affordable senior housing and services in Monroe County, particularly the town of Irondequoit. All apartments will be handicap visitable or accessible, with seven fully wheelchair accessible units and three designed for residents with hearing and/or visual impairments. Each unit will come with a fully equipped kitchen, including Energy Star appliances; a living/dining area; central air conditioning; individually controlled heat and electric; off-street parking; an emergency call system; intercom entry; and elevator access. Residents will also have access to laundry facilities on each floor, a community room and an outdoor courtyard.

Setting Durand apart from other affordable housing developments, however, will be the presence of St. Ann's Adult Day Service, a program providing both medical and social adult day care services to building residents and the greater Rochester community. The program, the first of its kind in the area, will open in early January 2019 and offer participants structured social activities, hot midday meals, assistance with medications and personal hygiene, wellness programs, entertainment and health monitoring. Perhaps the most significant benefit of the combined social/medical model, however, is that a participant enrolled for social activities who needs to transfer to the medical model because of changes in health will not need to move to another location. The program will include a registered nurse, clinical nutritionist, social worker, recreation therapist and certified nursing assistants who will collaborate with participants' primary care providers.

*Setting Durand apart from other affordable housing developments, however, will be the presence of St. Ann's Adult Day Service, a program providing both medical and social adult day care services to building residents and the greater Rochester community.*

The result of this partnership between Providence Housing and St. Ann's will be an innovative offering providing an enhanced level of care and convenience to Rochester-area seniors and their families. At the core of St. Ann's mission is the concept of "caring for the most important people on earth." Helping seniors at Durand and beyond to age in the community through safe, supervised care and social opportunities will go a long way toward fulfilling that purpose.

Rendering of Durand Senior Apartments

Ami Schnauber

# 2019 Legislative Outlook

The November midterm elections brought significant change to New York's political landscape at both the state and federal level. For the first time in nearly a decade, Democrats gained a majority in the State Senate, winning 40 of the 63 seats and securing full control of state government. Three Republican-held congressional seats flipped as well, allowing Democrats to regain control of the U.S. House of Representatives. As members of the House majority, many New York Democrats will have seniority and will likely hold some key leadership positions.

The Assembly Democrats will continue to hold an overwhelming majority under the leadership of Speaker Carl Heastie. However, we expect to see some changes in other key leadership and chairmanship positions because Majority Leader Joe Morelle was elected to Congress, and Deputy Speaker Earlene Hooper lost her primary. This could lead to several changes in committee chairs, though I expect that longtime Health Committee Chair Dick Gottfried will retain his position.

Perhaps the most significant change, with the biggest impact, is the flip of the majority in the Senate. All but two of the former IDC members lost their primaries, helping to shore up the Democratic Conference early on. Then, in the general election, Democrats were able to retain all of their seats and also oust several incumbent Republicans, including longtime Health Committee Chair Kemp Hannon. Democratic Senator Andrea Stewart-Cousins from Yonkers was selected as the first female majority leader of the New York State Senate at the end of November and will preside over the party's largest majority in over a century. This majority flip will mean that offices and chairmanships and leadership positions will change. The current ranking member of the Health Committee is Senator Gustavo Rivera, who could be the potential chair in January.

The new Congress convening in January will have a host of new members as well, given the number of seats that changed party control and the retirements of several longtime legislators. The House gained historic diversity, with more than 100 women winning seats and new African-American, Muslim, Latino/Latina and Native American representatives. With a new Democratic House majority, committee chairs will change, and Democrats will gain more seats on key committees with jurisdiction over Medicare, Medicaid, affordable housing and appropriations. Several New York Democrats will have seniority and will likely hold some key leadership positions in the new Congress, offering the state a stronger voice on federal issues.

*These changes offer challenges but also great opportunities to educate the incoming legislators on the long-term services and supports on which people rely as they age.*

I am particularly pleased that Assemblymen Anthony Brindisi and Joe Morelle won election to Congress. Both were strong advocates for aging services in the Assembly, with Brindisi taking the lead on pushing an SSI increase for assisted living and Morelle taking the lead on securing dedicated health care transformation grant funding for long term care providers. We expect to continue this strong collaborative relationship with them in their new positions.

These changes offer challenges but also great opportunities to educate the incoming legislators on the long-term services and supports on which people rely as they age. In addition to fighting unfunded mandates and any cuts to Medicaid and Medicare, we have several important pieces of legislation that we will be pursuing this year.

(See *2019 Legislative Outlook* on page 41)

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# 2019 Legislative Outlook ... (Continued from page 39)

## Legislation on the State Level

- **Role of the Nurse in an ACF:** We will be supporting legislation to allow adult care facilities (ACFs) to directly employ LPNs or RNs to provide nursing services.
- **Resident Assistants in Senior Housing:** We will be supporting legislation to establish a dedicated Affordable Independent Senior Housing Assistance Program. This program would bolster New York's historic commitment of $125 million to senior housing and create a very cost-effective model for seniors to age in place, either in the new housing constructed for them or in the preexisting housing where they reside. The model would also result in savings to the State's Medicaid program by keeping low-income seniors out of more costly levels of care, such as assisted living or nursing homes.

*While the number of CCRCs has grown considerably across the nation, only 12 CCRCs are currently operating in New York.*

- **CCRC Revitalization Act:** We will be supporting the Continuing Care Retirement Community (CCRC) Revitalization Act. CCRCs provide a full range of services including independent housing, ACF/assisted living and nursing home care to residents in a campus setting as their needs change. While the number of CCRCs has grown considerably across the nation, only 12 CCRCs are currently operating in New York. Comprehensive statutory and regulatory reforms are needed in order to modernize the CCRC laws in New York and eliminate barriers to their development, expansion and efficient operation.
- **Nurse Staffing Ratios:** We are opposing the Safe Staffing for Quality Care Act, legislation that would create specific staffing ratios for nurses and other direct care staff in hospitals and nursing homes. The staffing standards proposed in this legislation (upper end of range) would conservatively cost an estimated $1.06 billion to implement in nursing homes. It would require more than an hour of additional staff time per resident per day when compared to current staffing. The typical downstate nursing home would see a $15 per resident day cost increase if it were to increase aide staffing to meet the standard. For a home serving 200 residents, that would total $3,000 per day for increased aide staffing. LeadingAge New York's Staffing Ratios Cost Template will assist you in determining the financial impact of the proposed legislation on your facility.
- **Advanced CNAs:** We are advancing legislation that would establish a demonstration program authorizing Certified Nursing Aides (CNAs) who receive advanced training to administer medications in nursing homes under the supervision of an RN.

*We are opposing the Safe Staffing for Quality Care Act, legislation that would create specific staffing ratios for nurses and other direct care staff in hospitals and nursing homes.*

## Legislation on the Federal Level

- **Nurse Aide Training Lockout:** We have advanced the Nursing Home Workforce Quality Act, a bill that would make the nurse aide training lockout discretionary rather than mandatory, as it is under current law, and restore training authority once the nursing home is back in compliance, eliminating the current two-year lockout.

(See *2019 Legislative Outlook* on page 42)

## 2019 Legislative Outlook ... (Continued from page 41)

- **Medicare Observation Days:** We are supporting the Improving Access to Medicare Coverage Act, legislation that would resolve the observation days issue by requiring all time Medicare beneficiaries spend in a hospital to count toward the three-day stay requirement for coverage of any subsequent post-acute care.
- **Home Health Care Planning Improvement Act:** We are supporting the Home Health Care Planning Improvement Act, legislation that would allow nurse practitioners, physician assistants, clinical nurse specialists and other non-physician advance-practice professionals to order and certify Medicare home health services.

There will be many new faces in Albany and Washington, DC come January, and if you have a new legislator representing your area, now is the perfect opportunity to reach out, introduce them to your community and educate them on the issues that are important to you. Set up a time to visit or invite them to your organization to meet with your leadership team, staff, families and consumers.

*As always, if you have any questions or concerns, please feel free to contact the Advocacy and Public Policy team at 518-867-8383. Thank you again for your efforts!*

# Win the Job Hop by Staying Balanced

As scarcity in the talent market persists, employees aren't hesitating to take the opportunity to jump ship. Job-switching no longer retains the same stigma it has had in the past, and the practice is becoming more commonplace as offers improve and we continue to transition to the gig-based economy. This willingness to job-hop creates a challenge for employers – and an ***opportunity for recruiters***.

Though employees are more likely to take the leap these days, it doesn't mean they are going through a big job transition for no reason. People leave because they are dissatisfied, and they take offers because they see greener pastures ahead. What aspect of the job ultimately pushes them to make the change, though? Studies show that work-life balance is a major contributor in employee decisions to stay or go.

## Why is work-life balance so important?

According to ***one study,*** work-life balance issues account for 28 percent of employee departures; however, the statistics may be even higher. Flexible work schedules and the ability to work remotely are huge contributors to maintaining a successful work-life balance, and a ***Yoh survey*** confirms their importance in retaining employees. The study returned a result of 42 percent of employees saying they would leave their current job for a more flexible work environment.

*Studies show that work-life balance is a major contributor in employee decisions to stay or go.*

This is startling when you consider that ***nearly a quarter*** of workers claim their jobs interfere with their relationships with their children and significant other. That is a sizable chunk of the workforce that is at risk for departure (or that could be free for the taking).

## Not the benefits you want, but the benefits you need

As the hiring game gets more competitive, expectations are growing for employers to provide flexible scheduling and other benefits that promote work-life balance. Even the retail industry is increasing benefits due to its problems with retention; Walmart, Lowe's and Starbucks are all offering paid parental leave to even their hourly employees.

When vying for talent using work-life balance, be sure to showcase your truly valuable benefits. Don't make the mistake of throwing in every trendy office perk you can offer. ***73 percent of employees*** say they would not leave their job for on-site gyms, daycare services, game rooms or other office-lifestyle enhancing perks.

*Providing benefits such as flexible work hours, parental leave and remote work options are vital to retaining and attracting employees.*

Providing benefits such as flexible work hours, parental leave and remote work options are vital to retaining and attracting employees. This is especially true as workers progress in their lives and careers, becoming more valuable to your company and more established in their personal relationships. Providing long-term benefits, such as career paths that don't require relocation, is a way to attract and retain talent for the future.

(See *Win the Job Hop* on page 44)

LeadingAge New York Career Center
Connecting Talent and Opportunity

# Win the Job Hop ... (Continued from page 43)

## Don't stop there

Having benefits available is a great way to get talent in the door, but in order to keep that talent, employers have to take things a step further. Offering PTO and flexible work is not enough on its own; the company culture has to support the use of these benefits. In one study, Science Daily found that ***40 percent of respondents*** believed that using their PTO would jeopardize their careers and slow advancement at their company.

If employees do not feel free to use the benefits provided to them, the benefit of retainment is lost for the employer. These workers are just as likely to jump ship for a company with a perceived better company culture, one that they feel will support them in both their lives and careers. It is therefore important to listen to employee feedback for guidance on how to retain workers for the long term and improve work-life balance at your organization.

Emphasis on work-life balance will mean more investment in your employees' personal well-being. In the end, however, you'll have a less stressed, more productive workforce and a company culture that will attract high quality candidates.


*If employees do not feel free to use the benefits provided to them, the benefit of retainment is lost for the employer.*

## Fee After Fee

Are you currently posting help wanted ads to those sites that charge a per day rate with click fees? Stop and post your ad to the LeadingAge New York Career Center. One low monthly fee includes posting to those click fee sites! Visit the LeadingAge New York Career Center today to take advantage of this great value.

For more information on winning the job hop by staying balanced, go to ***www.leadingageny.org*** and click on ***Career Center*** at the top of the page.

**All Noteworthy stories link to the main "Member News" page where stories are listed by date, with the most recent postings first. Send us your news stories and be featured in the next issue of *Adviser*.**

# MEMBER NEWS
# NOTEWORTHY

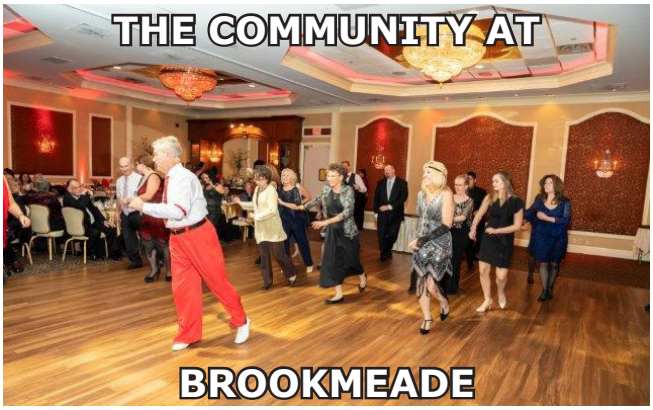

***Health Care Professionals Told Their Work Continues Jesus' Mission*** Cardinal Dolan served as principal celebrant and homilist at the June 7th Mass in St. Patrick's Cathedral, and he was joined by nearly 20 concelebrants, including a visiting prelate, Bishop Matthew K. Gyamfi of the Diocese of Sunyani in Ghana, Africa. ArchCare, the archdiocese's health system, sponsors the Mass, celebrating the work of health care professionals and caregivers. 6/22/2018


***LeadingAge New York Presents Award to Sen. Robach, Proudly Nominated by Friendly Home Team*** On Oct. 23rd, the Friendly Home hosted an award ceremony after nominating Sen. Joseph E. Robach for LeadingAge New York's Partners in Quality Award for his commitment to supporting Rochester's senior community, specifically individuals living at the Friendly Home in Brighton. 11/5/2018


***US News Ranks Northwell Rehabilitation Centers Among Nation's Best*** Northwell Health's Stern Family Center for Rehabilitation in Manhasset and Orzac Center for Rehabilitation in Valley Stream have each earned the highest five-star ranking in U.S. News & World Report's annual Best Nursing Homes report. 11/15/2018

(See Noteworthy on page 46)


***St. Camillus Receives $200,000 NYS Grant, Honors Retiring Sen. John A. DeFrancisco*** The Centers at St. Camillus announced that it has received a $200,000 New York State Legislative Grant for capital improvements to its health care facility that was championed and secured by New York State Senator John A. DeFrancisco, who is officially retiring at the end of this year. 9/10/2018




***The Seventh Annual Brookmeade Gala: Roaring 20s*** On November 17th, the Brookmeade Community Foundation hosted the Seventh Annual Brookmeade Gala at the Grand Hotel Poughkeepsie, honoring Rhinebeck at Home and Christene Marshall, director of activities at Baptist Home. 11/26/2018


***Resident Volunteers Computer Expertise to Create an Information Website for Bethel Staff*** Paul Schmidt, a short-term resident at Bethel Nursing and Rehabilitation Center and a native of Yonkers, is helping to develop an internal website that will provide information for Bethel staff in a variety of areas, from how to use the mail machine to a quick reference on Bethel's computer software programs. 11/7/2018

NOTEWORTHY NEWS
For more member news click here to go directly to the LeadingAge New York site.

MEMBER NEWS
# NOTEWORTHY


***St. Johnland Honors Resident Veterans*** St. Johnland Nursing Center honored resident veterans and those in the adult daycare program with a special luncheon to recognize their service to the country. 11/13/2018


***Newest PACE Center Dedicated at Cabrini of Westchester*** ArchCare's Senior Life Program of All-Inclusive Care for the Elderly (PACE) center opened on the campus of Cabrini of Westchester in Dobbs Ferry on June 25th. 7/9/2018

(See Noteworthy on page 47)


***The Benefits of Creativity*** The Carter Burden Network's free Making Art Work classes give seniors an opportunity to take art classes taught by professionals and connect with the community. 7/27/2018


***Camphill Ghent Honored With LeadingAge National Award for Culture of Diversity and Inclusion*** Camphill Ghent received the 2018 Hobart Jackson Cultural Diversity Award from LeadingAge. Camphill Ghent's executive director, Onat Sanchez-Schwartz, and Board chairperson Jerry Schwartz accepted the award at the LeadingAge national conference in Philadelphia. 9/21/2018


***St. Ann's Community Walks to End Alzheimer's, Takes Top Fundraising Spot for 3rd Consecutive Year*** St. Ann's Community employees participated in the 2018 Walk to End Alzheimer's on Oct. 20th. Over 220 employees registered to walk at Frontier Field along with over 2,000 participants from the Rochester area. 10/29/2018


***Glenmere at Cloverwood Celebrates Grandparents Day & National Assisted Living Week*** The residents and staff of Glenmere at Cloverwood celebrated Grandparents Day and National Assisted Living Week with a circus-themed party. 9/21/2018


***Fox Run at Orchard Park Named One of the 2018 Best Workplaces for Aging Services by Great Place to Work® and FORTUNE*** Great Place to Work and FORTUNE have honored Fox Run at Orchard Park as one of the 2018 Best Workplaces for Aging Services. 10/5/2018

(See Noteworthy on page 48)

NOTEWORTHY NEWS

For more member news click here to go directly to the LeadingAge New York site.

MEMBER NEWS

# NOTEWORTHY


***7th Annual North Fork-Based End of Summer Celebration and Fireworks Show Blasts Off Over Labor Day Weekend*** Peconic Landing held its seventh annual End of Summer Celebration and Fireworks Show on Sept. 2nd. The celebration is a way for the members of Peconic Landing and staff to come together with the East End community. 8/30/2018


***Many Area Nursing Homes Rated as Average or Above*** Nearly 3,000 nursing homes across the country, including 72 in New York, received U.S. News & World Report's Best Nursing Home designation this year. Woodland Pond at New Paltz in Ulster County was among that group. 11/6/2018


***VRS Celebrates Grand Opening of New Enriched Housing Apartments*** It was an exciting day for Valley Residential Services' residents, staff, families, friends and dignitaries as the ribbon was cut on its newest addition of Enriched Housing and Assisted Living apartments on Sept. 26th. 9/28/2018


***Gurwin's Adult Day Health Program Receives Top Recognition*** Gurwin Jewish Nursing & Rehabilitation Center, located in Commack, recently announced that its Adult Day Health Program has been named number one in Adult Day Care Programs on Long Island, according to the 2018 Long Island Business News (LIBN) Reader Ranking Survey. 11/6/2018

(See Noteworthy on page 49)


***Jefferson's Ferry Residents Raise Funds to Support Low Cost and Free Breast Cancer Screenings*** In recognition of Breast Cancer Awareness Month, a cadre of Jefferson's Ferry residents and staff held a bake sale to benefit the Fortunato Breast Health Center at John T. Mather Memorial Hospital, which offers no cost or discounted screenings to uninsured or underinsured patients. 11/6/2018


***Former House Speaker Nancy Pelosi Makes Hebrew Home Stop*** Democratic Minority Leader and Former House Speaker Nancy Pelosi stopped by the Hebrew Home at Riverdale to visit with more than 100 residents and a couple dozen students at the Palisade Avenue campus. 6/8/2018


***Beechwood Continuing Care Honored for its Commitment to Those With Disabilities*** Beechwood Continuing Care has received the Employer of the Year Award for 2018 from the Cerebral Palsy Associations of New York State. The award recognizes a business "that has made a commitment to provide employment opportunities to individuals with disabilities and has made the accommodations necessary for access to jobs." 11/7/2018


***Elizabeth Seton Pediatric Center Celebrates 30 Years of Caring for Children with Medical Complexities*** The Elizabeth Seton Pediatric Center, which in recent years has grown to become the largest children's post-acute care facility in the United States, celebrated its 30th anniversary on Sunday, September 23, 2018. More than 500 children, family members, staff and special guests joined. 9/25/18



(See Noteworthy on page 50)


***Shaker Pointe at Carondelet Announces Plans for New Building*** The Sisters of St. Joseph and the Leadership of Shaker Pointe at Carondelet, an active senior living community in Latham, with The Most Reverend Howard J. Hubbard, Bishop Emeritus, announced its plans for the addition of a new building on its campus. The structure, called Parkland at Shaker Pointe, will include 35 Independent Living apartments for seniors 55 and over. 9/20/2018


***Loretto Announces $11M Project at Three Buildings to "Expand and Enhance" Dementia Care*** Loretto has plans for an $11 million project involving renovations and new construction to "expand and enhance" dementia care at three of its locations. They include The Nottingham in DeWitt, along with the Heritage and the Cunningham buildings on Loretto's main campus in Syracuse. 10/30/2018


***Wayne County Nursing Home Sponsors "Throwback Thursday" Event for Staff*** Wayne County Nursing Home recently sponsored a "Throwback Thursday" event for staff. Staff were invited to spend some time in the meditation room, which was decorated with photos of residents and staff from the past. Special snacks were provided as well. 11/20/2018


***Grand Opening of The Brookmeade Courtyard: Special Tribute*** The Baptist Home at Brookmeade hosted a ribbon-cutting ceremony conducted by the Rhinebeck Area Chamber of Commerce with special guest Senator Sue Serino on June 22nd for The Brookmeade Courtyard, which has the ambiance and amenities of a beautiful park enjoyed by its residents and location for many community events. 6/25/2018

(See Noteworthy on page 51)


***Parker Jewish Institute Announces Grand Opening of New Indian Cultural Unit*** Parker Jewish Institute for Health Care and Rehabilitation held a grand opening ceremony on September 17th for a new Indian Cultural Unit, dedicated to enhancing quality of life for patients, residents and families. 9/18/2018


***First Person: Our New Geriatric Career Program at Ovation Communities*** The New Jewish Home's Geriatric Career Development Program, an innovative program that seeks to inspire at-risk students and create the next generation of health care professionals, is now being modeled at Ovation Communities in Milwaukee, Wisconsin. 10/15/2018


***Park Ridge Living Center Receives Coveted Pathway to Excellence Designation*** Park Ridge Living Center is the first long term care facility in New York State to earn the Pathway to Excellence designation from the American Nurses Credentialing Center. Park Ridge now joins an elite club of only seven other long term care facilities in the U.S. to receive this national recognition. 10/19/2018


***The Osborn Expands Medical Services for Campus Residents*** The Osborn has announced that it is partnering with Northeast Medical Group, a division of Yale New Haven Health, to offer medical services to residents in Independent Living and Assisted Living on its Rye campus. 8/14/2018


***United Hebrew Short-Term Rehab Earns Top Rating from US News & World Report*** In the just-issued U.S. News & World Report quality ratings for short-stay facilities, United Hebrew of New Rochelle's short-term rehabilitation center came out on top, earning the highest possible "high performing" rating. 11/26/2018

(See Noteworthy on page 52)

# NOTEWORTHY

## Amsterdam Continuing Care Health System, Inc. Honors:

*LeadingAge New York's Trustee of the Year*

Lawrence B. Thompson

*LeadingAge New York's Employee of Distinction*

Stephanie Catapano

## Amsterdam Nursing Home Corporation Names:

*Vice President of Nursing*

Gertrudes DeGuzman

## Andrus on Hudson Names:

*Director of Community Life*

Leslie Hoot

*Director of Marketing*

Daniel Serafini

## Beechwood Continuing Care Names:

*Director of Spiritual Care*

Ken Keenan

## Bethel Nursing and Rehabilitation Center Names/Celebrates:

*Director of Nursing Services*

Colleen Melville, RN

*Employee of the Month*

Fitzroy Genus

## Elizabeth Seton Pediatric Center Names/Celebrates:

*Vice President of Operations*

Adriene Rosell, CNHA, FACHCA, MHA

*LeadingAge New York's Employee of Distinction*

James Maxson

(See Noteworthy on page 53)

## Friendly Senior Living Names:

*Chief Financial Officer*

Christine Johnson

*Finance Director*

Linda Kant

## Good Shepherd Communities Recognizes/Names:

*LeadingAge New York's Employee of Distinction*

Christopher Norwood

*LeadingAge New York's Employee of Distinction*

Dawn Coleman

*LeadingAge New York's Employee of Distinction*

Janet Allard

*Chief Financial Officer*

Alan Runde

## Gurwin Jewish Nursing & Rehabilitation Center Names:

*Senior Vice President and Chief Operating Officer*

Shua Sauer

## Hebrew Home at Riverdale Celebrates:

*Senior Staff Attorney "36 Under 36"*

Malya Levin

## Lutheran Welcomes:

*Board Chair Lutheran Jamestown*

Terry Havens-Turner

*Board Chair Lutheran Foundation*

Joel Gaden

## New York City Health & Hospitals Corporation Names:

*Chief Financial Officer*

John Ulberg Jr.

## Parker Jewish Institute for Health Care and Rehabilitation Celebrates:

*2018 Humanitarian Award*

Michael Rosenblut

(See Noteworthy on page 54)

NOTEWORTHY

NEWS

For more member news click here to go directly to the LeadingAge New York site.

MEMBER STAFF CHANGES/HONORS/CELEBRATIONS

# NOTEWORTHY

## The New Jewish Home Names:

***Housing Administrator***

Eli Skoczylas

***Director, Solutions at Home***

Eileen Zenker

***Director, Adult Day Health Care***

Meg Sherlock

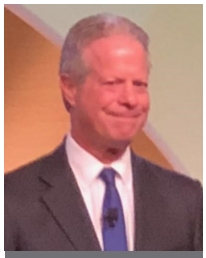
## Presbyterian Home for Central New York, Inc. Names:

***Administrator***

Bryan Ehlinger

## RiverSpring Health Celebrates:

***Award of Honor***



Daniel Reingold

## The Centers at St. Camillus

***Celebration of Service***

Michael J. Byrne

Shirley Cruickshank

## The Friendly Home Names:

***Volunteer Coordinator***

Kathy Main

## Valley Health Services, Inc. Welcomes/Names/Celebrates:

***Certified Occupational Therapy Assistant***

Beth Rowe

***Licensed Practical Nurse***

Danielle Morczek

***Employee of the Third Quarter 2018***

Clarinda Luppino

***Employee of the Year 2018***

Michelle Neff

## Wartburg Celebrates:

***Distinguished Professor of Creative Arts***

Dr. Concetta M. Tomaino

***LeadingAge New York's Trustee of the Year***

Rev. Amandus J. Derr

## St. Johnland Nursing Center Names: *Director of Nursing*

Michele Randazzo, RN, BS, MBA

# NOTEWORTHY

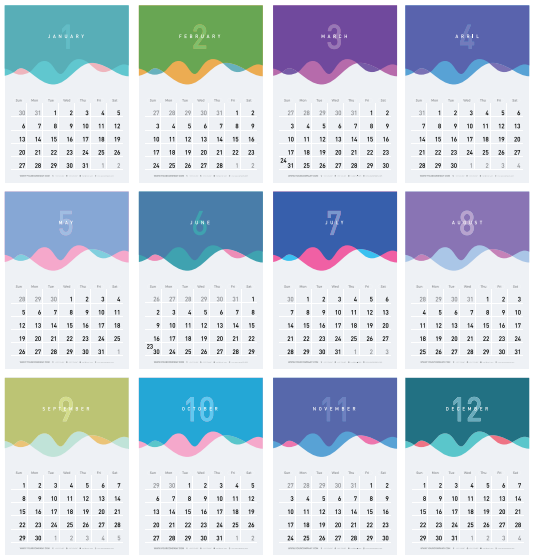
## LEADINGAGE NEW YORK NEWS

2019

**DATES ANNOUNCED**

**LeadingAge New York**

**Events & Education**



For more information on upcoming events *click here.*

### Welcome New Members

**Primary Members:**

The Pines Healthcare and Rehabilitation Centers-Machias Campus

**Primary Members – Under Construction CCRC:**

River's Edge

Fountaingate Gardens

New York Foundation on Aging ALP

**Associate Plus Members:**

Steven Herbst, Principal Mazars USA LLP

**Retiree Members:**

Rocco Meliambro

Michael Perry



**To feature your news items with LeadingAge New York send press releases to Kristen Myers at *kmyers@leadingageny.org***