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Strengthening and Promoting the Linen, Uniform and Facility Services Industry

Why Outsource Laundry Now?

FIVE KEY FACTORS

MINIMUM WAGE HIKES

INCREASED REGULATION

SAFETY CHALLENGES

DECREASED REIMBURSMENT

LINEN SERVICE INTEREST

Why Outsource Laundry Now? Five Key Factors

As uncertainty regarding the viability of long-term care providers' revenue sources increases, concern about margins is prompting greater scrutiny of all expense line items. Such examination is extending beyond the most costly line items to a variety of others that could be decreased without compromising patient care. This includes ceasing in-house laundry operations and outsourcing this work to a linen service provider, which can reduce annual costs by five figures in even the smallest long-term care facility. It's time for every provider in the industry still operating an on-premises laundry (OPL) to take this step.

Three major cost factors:

- Minimum wage increases in various U.S. states, with more on the way in others, are driving up labor costs
- Industry-specific regulation, including new Centers for Medicare and Medicaid Services (CMS) rules, is imminent
- Workplace safety improvement is declining, a negative for reducing workers' compensation premiums and associated injury/illness costs

Overriding revenue factor:

- Reimbursement sources (Medicaid, Medicare, private pay) are more dubious than ever

Opportunity factor:

- Savings by outsourcing laundry are likely greater than ever as OPL costs rise linen service providers' interest in serving long-term care facilities grows

TRSA, the Association for the Linen, Uniform and Facility Services Industry, is presenting this discussion of these factors to support cost-control efforts in the long-term care industry. Impacts of the first four factors are often difficult to mitigate. Their potential to damage margins is substantial. Any manager in long-term care aiming to reduce any expense can cite them as reason to move ahead with cost reduction strategies and tactics. The fifth factor supports giving OPL shutdown priority in this respect.

Factor 1: Minimum Wage Increases

Minimum wages increased in 19 states and 21 cities at the onset of 2019 (National Employment Law Project)[1]. Before the year is out, three more states and 18 cities and counties will follow. In 13 cities and counties, the minimum wage will reach or exceed $15 per hour.

These developments are fulfilling the predictions of a 2017 study by RTI International and the Center for Excellence in Assisted Living[2], which determined that raising the minimum wage to $10, $12, or $15 an hour has a large impact on workers and employers in skilled nursing facilities and continuing care retirement (CCR) communities. Nationally, most employees (86 percent or more) in each key job category would be affected by a $15 minimum wage and many fewer employees would be affected by a $12 minimum wage (58 percent or more) or a $10 minimum wage (27 percent or more).

Calculating the Payroll Impact

The federal Department of Labor (DOL) counted 862,700 employees in skilled nursing and CCR in 2015. Table 1

1 "Workers Getting Raises As 19 States And 21 Cities Increase Minimum Wage in the New Year" National Employment Law Project, December 27, 2018

2 Elkins, Wendi; Lepore, Michael; Wiener Joshua M.; *Impacts of Potential Minimum Wage Increases on Assisted Living and Continuing Care Retirement Communities*, RTI International, Washington, DC, September 2017

shows 75 percent of them were in occupational categories likely to experience wage increases in line with regulated minimum wage hikes. Other DOL data (Bureau of Labor Statistics) showed these job classifications received 70 percent of the wages paid in the broader nursing and residential care sector[3], which includes skilled nursing, CCR, mental health and other residential care facilities; in skilled nursing alone, the figure was 81 percent[4].

Table 1—Workers by Key AL and CCRC Labor Categories, 2015

Occupational Category	Number	Percentage
Healthcare Support-Related Occupations	264,330	30.6%
Personal Care and Service-Related Occupations	161,660	18.7%
Food Preparation and Serving-Related Occupations	152,580	17.7%
Building and Ground Cleaning and Maintenance-Related Occupations	56,980	6.6%
Healthcare Practitioners and Technical-Related Occupations	91 ,220	10.6%
Management-Related Occupations	26,570	3.1%
Office and Administrative Support-Related Occupations	46,310	5.4%
Other	63,050	7.3%
Total	**862,700**	**100.0%**

The national median hourly wage for the key labor categories specific to skilled nursing and CCR ranged from $10.12 to $11.28. Table 2 reports the national distribution of hourly wages for key labor categories at the 10th, 25th, 50th, 75th, and 90th percentiles. Researchers factored these percentiles into their calculation of the hikes' overall industry impact, as each occupational group would be affected slightly differently by increasing the minimum wage to $10, $12, or $15 per hour.

Table 2—National Distribution of Hourly Wages for Key AL and CCRC Labor Categories, 2015

Occupational Category	Hourly				
	10th%	25th%	50th%	75th%	90th%
Personal Care and Service-Related Occupations	$8.48	$9.34	$10.64	$12.26	$14.92
Food Preparation and Serving-Related Occupations	$8.48	$8.97	$10.12	$12.26	$15.73
Building and Ground Cleaning and Maintenance-Related Occupations	$8.42	$9.25	$10.66	$12.62	$15.49
Healthcare Support-Related Occupations	$8.77	$9.87	$11.28	$13.40	$15.29

A substantial proportion of staff would require wage increases in each of the key job categories if the minimum hourly wage level were increased to any of these levels, as indicated in Table 3. For example, increasing the minimum wage to $12 would require wage increases for 58 percent to 71 percent of workers. The greatest percentage (71) requiring increases were in food preparation and serving.

Hygienically Clean Healthcare is the quantified, validated standard and measure for healthcare textiles in North America since 2011. When long-term care facilities review linen service options, every laundry under consideration should be Hygienically Clean Healthcare certified. The certification reflects laundries' commitment to best management practices (BMPs) and their capability to produce clean textiles as quantified by ongoing microbial testing.

3 Employment by industry, occupation, and percent distribution, 2016 and projected 2026, Nursing and residential care facilities, Bureau of Labor Statistics, https://www.bls.gov/emp/tables/industry-occupation-matrix-industry.htm

4 Employment by industry, occupation, and percent distribution, 2016 and projected 2026, Nursing care facilities (skilled nursing facilities), Bureau of Labor Statistics, https://www.bls.gov/emp/tables/industry-occupation-matrix-industry.htm

Table 3—Percentage of Staff in Key AL and CCRC Labor Categories Requiring Wage Increases, 2015

Job Category	$10	$12	$15
Personal Care and Service-Related Occupations	37%	70%	90%
Food Preparation and Serving-Related Occupations	47%	71%	86%
Building and Ground Cleaning and Maintenance-Related Occupations	38%	67%	86%
Healthcare Support-Related Occupations	27%	58%	87%

Across all job categories, a 70-cent increase would be needed if the wage were set to $12 and $3.40 if set to $15. Overall, the wage increase required at each minimum wage level was similar across job categories but lower for healthcare support if the wage level were set to $10 or $15.

Table 4 shows the national average annual wage and payroll tax increases required per full-time worker in key job categories by minimum wage level (i.e., $10, $12, and $15). Across the board, increasing the minimum wage would require annual and wage payroll tax increases per worker of roughly $1,500 if set to $10, roughly $3,500 at $12, and roughly $7,500 at $15.

Table 4—Average Annual Wage and Payroll Tax Increase Required per Full-Time Worker in Key AL and CCRC Job Categories by Minimum Wage Level, 2015

Job Category	$10	$12	$15
Personal Care and Service-Related Occupations	$1,567	$3,269	$7,501
Food Preparation and Serving-Related Occupations	$1,635	$3,941	$8,486
Building and Ground Cleaning and Maintenance-Related Occupations	$1,612	$3,426	$7,680
Healthcare Support-Related Occupations	$1,455	$3,672	$6,270

Calculating the Overall Impact

Table 5 displays the aggregate impact on the industry from these increased wages and payroll taxes alone. The research report also speculated on the other economic impacts that could result from such increases.

Table 5—Total Wages and Payroll Tax Increases across All Workers in Key AL and CCRC Job Categories per Year by Minimum Wage Level, $Millions, 2015

Job Category	$10	$12	$15
Personal Care and Service-Related Occupations	$93.70	$369.90	$1,019.30
Food Preparation and Serving-Related Occupations	$117.20	$426.90	$1,113.50
Building and Ground Cleaning and Maintenance-Related Occupations	$34.90	$130.70	$376.30
Healthcare Support-Related Occupations	$103.80	$562.90	$1,441.60
Total	**$349.60**	**$1,490.40**	**$4,022.70**

Regarding possible impacts from payers, Medicaid fee-for-service (FFS) or managed plans might not increase their reimbursement rates to compensate for these higher costs. No Medicaid law or regulation requires them to do so. Some state Medicaid programs have not increased their payment rates after state increases in the minimum wage. Low Medicaid reimbursement rates are already a barrier to access to residential care in some states.

Long-term care facilities operators could:

- Pass the increased costs to consumers through higher prices. But this might reduce demand and result in lower occupancy rates. This is more likely to have an impact on lower performing operations than those with waiting lists. Some providers would likely have excess demand that would absorb a rate increase. That's likely a minority today: in 2010, 28 percent of residential care facilities in a national survey reported at least one resident moving out of the community because of price.
- Offset the cost of a wage increase by reducing operating margins already stretched thin. The most recent Clifton Larson Allen report on skilled nursing[5] quotes the Centers for Medicare and Medicaid Services (CMS) putting the industry's 2017 median operating margin at 0. This reflects profitability from primary

5 *33rd Edition Skilled Nursing Facility Cost Comparison Report – An Industry in Transition*, Clifton Larson Allen, Minn., 2019

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revenue sources, excluding contribution and investment income.

Note the alternative the researchers identified most pertinent to this paper: "implement a variety of initiatives involving nonlabor costs, such as providing lower-cost food and spending less on environmental amenities. Alternatively, they could reduce labor costs by finding more efficient methods of providing services." Laundry would certainly fall into the latter category.

Factor 2: Industry-Specific Regulation

The likelihood that nursing homes will be steadily subjected to greater regulatory activity for the foreseeable future seems certain. While the Obama Administration's 2016 rule restricting pre-dispute arbitration agreements hasn't materialized, public outrage over patient neglect or abuse won't subside any time soon. Advocacy organizations such as the National Consumer Voice for Quality Long-Term Care (Consumer Voice) and the Center for Medicare Advocacy are poised to advance their agenda of increasing the legal load on nursing home operators, including stronger enforcement.

Consider how developments add fuel to these organizations' fire:

- Jurors ruled in late April that Grace Healthcare of Tucker, Ga. should pay a patient's estate $1.8 million for the pain and suffering she experienced for 31 days after she tumbled from her bed[6]. The facility's policy says that two aides must help with changing linens when a resident is in bed because the facility does not use bedrails or restraints. On the day of the patient's fall, only one aide handled the 70-year-old's sheets, using too much force and causing her to tumble and hit her head. She died a month later. Jurors agreed with Grace Healthcare that Mitchell's death stemmed from a myriad of health issues and not just the head trauma. But they determined that the home failed to properly administer care, leading to the fall and leaving her in pain during her final days.
- In May, an appellate court upheld a $1.2-million fine levied against Putnam Center in Hurricane, W. Va., a nursing facility that failed to follow through on the extraction of one resident's teeth[7]. Surveyors alleged the operator failed to secure dental treatment for a 62-year-old resident whose decaying teeth caused several other health problems, including infections from bacteria traveling into his lungs. The nursing facility's medical director at the time deemed that the man had too many health issues to have his teeth extracted under a general anesthetic. Surveyors also alleged that the nursing home failed to schedule the extraction at a later date after the resident underwent a procedure that greatly improved his health.
- New York imposed a nearly $86,000 penalty in April against Safire Rehabilitation Southtowns of Buffalo[8]. Inspectors found in 2016 that a licensed practical nurse did not disinfect a shared blood glucose meter when testing upward of 20 residents, two with known communicable, bloodborne diseases. LPNs used alcohol swabs, rather than the proper germicidal or bleach wipes, to clean the meters, the department found. The federal Centers for Disease Control and Prevention (CDC) recommends use of individual glucose meters. State Department of Health inspectors reported the facility went without an infection control nurse for a year and had not trained all staff on proper procedures during that period.

Rules to be implemented this year governing operating procedures and reimbursement reflect government concern over such mishaps.

Phase 3 Deadline

A recent Consumer Voice webinar[9] reported the additional cost pressure on the industry to implement key provisions of Phase 3 of the 2016 update of the CMS Requirements of Participation for Long-Term Care Facilities, the first comprehensive revision to the regulations since they were issued in 1991. Implementation of these provisions is required on November 19:

Infection Preventionist (IP). A Kaiser Health News analysis of four years of federal inspections found 74% of nursing facilities were cited for infection control deficiencies. CMS's answer: every facility now must designate one or more IPs who are responsible for an infection prevention and control program (IPCP).

6 "Nursing Home Found Not Responsible for Death, But Still Must Pay $1.8M," *McKnight's Long-Term Care News*, May 2, 2019
7 "Appellate Court Upholds Nursing Home's $1.2-million Fine for Inadequate Dental Care," *McKnight's Long-Term Care News*, May 9, 2019
8 "Nursing Home Must Pay $85k Fine for Improperly Cleaning Glucose Meters," *McKnight's Long-Term Care News*, April 29, 2019
9 *Overview of Phase 3 Nursing Home Regulations: A Look Ahead*; webinar; National Consumer Voice for Quality Long-Term Care, April 9, 2019

Prior phases set requirements for IPCPs and antibiotic stewardship. To comply with Phase 3, CMS assumes facilities will designate RNs as IPs and that IPs will spend 15% of their time on such programs. As Figure 1 indicates, cost to the industry is estimated to approach $300 million.

Figure 1—Infection Prevention Cost to All Providers Combined

15% of full-time equivalent RN × $61 average hourly RN rate × 2080 hours (40 hours/week × 52 weeks) × 15,653 facilities =

$298 million

IPs must:

- Have primary professional training in nursing, medical technology, microbiology, epidemiology, or some other related field.
- Be qualified by education, training, experience, or certification.
- Work at least part-time at the facility.
- Have completed specialized training in infection prevention and control.

Compliance and Ethics Program. The ACA requires facilities to have such a program that effectively prevents and detects criminal, civil, and administrative violations and promotes quality of care. This is about a $110 million hit (Figure 62) requiring the industry to:

- Adopt written compliance and ethics standards, policies, and procedures
- Effectively communicate these
- Take "reasonable steps" to achieve compliance
- Assign individuals to oversee these programs
- Dedicate "sufficient resources and authority" to them
- Enforce them consistently
- Appropriately response to detected violations that are detected

Organizations with five or more facilities, which are expected to economize on this cost by assigning a higher-paid professional to the job than an RN but will do it more efficiently across locations, must also:

- Have mandatory annual training
- Designate a compliance officer (for whom the program is a "major responsibility")
- Designate a compliance liaison at each facility

Figure 2—Compliance/Ethics Compliance Cost Per Facility

6919 Facilities
Companies with 4 or Less
10% of FTE × 2080 × $61 × 6919 =
Segment Total $88 million

8734 Facilities
395 Companies with 5 or More
30% of FTE × 2080 × $85 × 395 =
Segment Total $21 million

Quality Assurance and Performance Improvement (QAPI). All facilities had to give a copy of their plan to surveyors annually starting November 28, 2017. Starting this November, the plan must be presented to federal or state surveyors at each annual recertification survey and upon request during any other survey as well as to CMS upon request.

Call System. A resident must be able to "call for staff assistance through a communication system which relays the call" from bedside and bathroom. The system may communicate with a nurse's station or directly with staff, with either audible or visual signals, according to surveyor's guidelines.

Training. New requirements are in place for staff, contract employees and volunteers consistent with their expected roles. Based on facility assessment of residents and resources, training must be performed at least

annually and may include in-person instruction, webinars and supervised practical training hours.

Curricula must include learning objectives, performance standards, and evaluation criteria. Instruction needs to address potential risks to residents, staff and volunteers if procedures are not followed. Facility must track staff participation in required trainings. Required topics include:

- Behavioral health services
- Compliance and ethics
- Effective communication
- Identifying and reporting abuse, neglect and exploitation
- Infection control
- QAPI
- Resident's rights and facility responsibilities

Also required by the November deadline: orientation and training on abuse prevention and in-service training for nurse aides.

Patient-Driven Payment Model (PDPM)

The onset of PDPM this October changes the rules for Medicare FFS reimbursement immediately and likely represents just the beginning of an altered payment equation that will include Managed Medicare (Advantage) and Medicaid. Expect those payers to follow in basing reimbursement on the complexity of patients' conditions as opposed to the volume of therapy they require.

CMS will no longer support the existing Resource Utilization Group (RUG) system starting in the fall of 2020, Robert Lane, who directs post-acute care services at BKD CPAs and Advisors, told the American College of Health Care Administrators in March. Even if this didn't occur, existing Medicare Advantage typically base their rate calculations on the Medicare system and would follow suit anyway[10].

Given that some Medicare Advantage and state Medicaid programs are already learning toward reimbursing by case mix, their conversion is likely to accelerate.

Payers that use the RUG system will have until September 30, 2020 to adjust their Medicare rate calculations accordingly. The variety of changes adds to the already heavy pressure on skilled nursing staff to code and bill properly and work the models concurrently. "What's the opportunity there for mistakes to be made?" Lane posited.

Under RUG, introduced in the Clinton administration, therapists often dictated a resident's overall care plan. Now nurses will return to this quarterback role. Signature HealthCARE, for example, indicated it would prepare for PDPM by adding 600 nurses between March and October. Management wants lower nurse-to-resident ratios to provide the most patient-centric care possible.

Such expansion is supported by consistent funding of providers by the base nursing reimbursement rate and pay for non-therapy ancillaries. Still, operators are urged to have frank discussions with their local Medicaid contacts and participating managed-care plans to forecast the true impact on profitability when RUG support finally disappears.

In addition to the initial compliance challenge, it's anticipated that the October Medicare shift will create liability issues. For years, skilled nursing and therapy providers faced governmental and legal scrutiny over providing too many rehabilitation hours. CMS has pointed to fraud reduction as a key selling point for PDPM, referring to "evidence of therapy being furnished to SNF patients on the basis of financial consideration rather than patient need" in its final rule. Fines under the False Claims Act included Signature HealthCARE paying $30 million to settle such allegations last June and Southern SNF Management seeing a $10 million fine the following month.

Now both providers and therapists face the completely opposite risk, facing accusation of not providing enough rehabilitation time for residents. Therapy, provided in-house or through a third-party partner, is shifting from a pure reimbursement vehicle to more of a cost that must be managed.

"With the change to PDPM, most third-party providers of rehabilitation services will look to change the contract. As a result, many patients may see a reduction in the total therapy hours provided, as the emphasis for reimbursement moves away from the total minutes for rehabilitation services provided," Timothy Ford, a partner

10 "PDPM's Effects Could Stretch Far Beyond Medicare for Skilled Nursing Facilities," *Skilled Nursing News*, March 19, 2019

at Einhorn Harris, told Skilled Nursing News. "Diligent plaintiffs' attorneys will try to use any reduction in the number of hours of therapy as evidence of neglect and malpractice."

Therapists haven't been concerned about liability as they haven't faced lawsuits and government scrutiny for providing too few hours. Negotiating new contracts will be contentious as skilled nursing providers seek shielding from liability for mistakes committed by their therapy partners and vice versa.

BKD notes on its website[11]: "All parties need to be aware that Medicare Administrative Contractors will be looking for providers with a dramatic reduction in therapy minutes from pre-implementation to post-implementation for the same clinical diagnoses. Just as driving 30 mph over the speed limit could result in a speeding ticket, this behavior more than likely will lead to significant citations and financial penalties."

Factor 3: Workplace Safety

Efforts by the federal Occupational Safety and Health Administration (OSHA) to build awareness of safety in nursing homes and reduce the industry's injury potential correlate with quantified success. States that passed legislation to improve such workplace safety can take credit for progress as well. Figures 3 and 4 show declines from 2013 to 2018 in the total recordable injury rate (TRIR) for private and public sector facilities in skilled nursing and the long-term care sector as a whole and drops in days away or restricted or transfer (DART) work.

Figure 3—Total Recordable Injuries

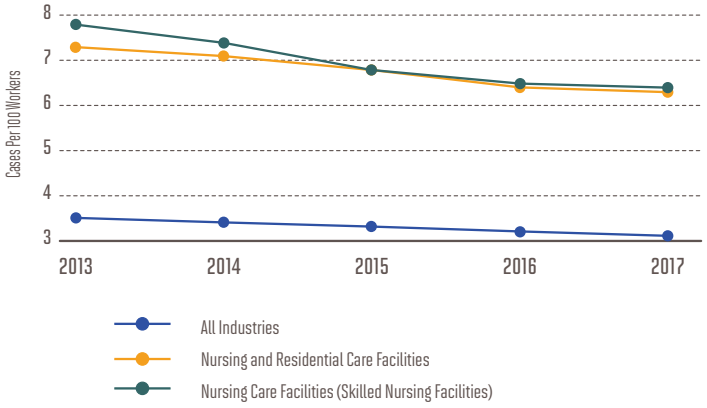


Figure 4—DART Rate

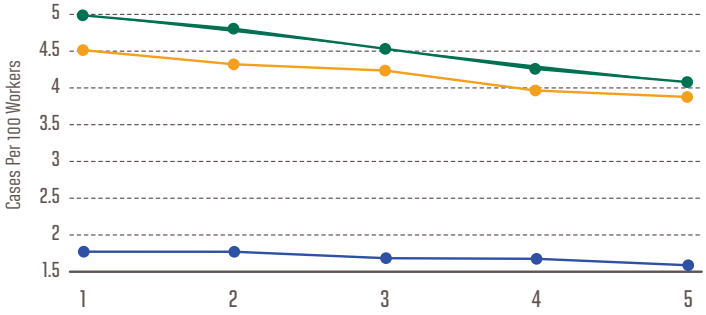


Figure 5—Total Recordable Injury Reduction Rate

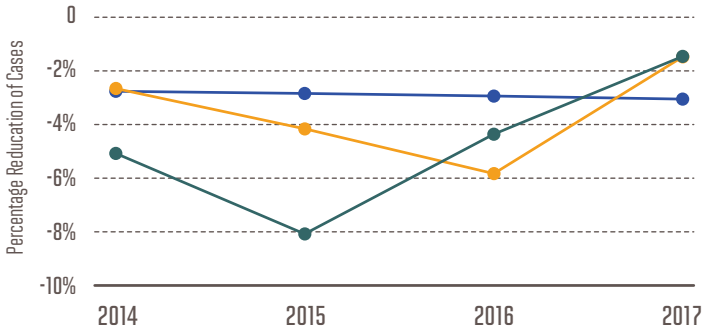
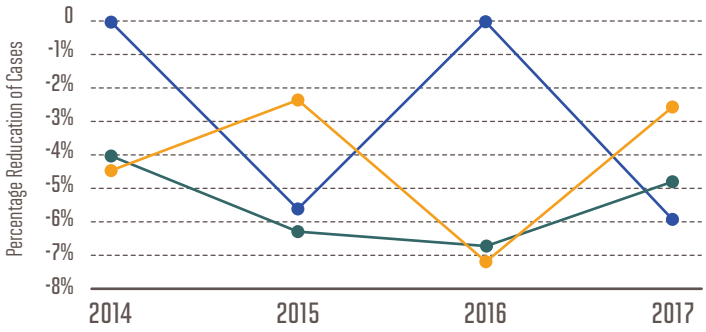


Figure 6—DART Reduction Rate



Source: U.S. Bureau of Labor Statistics

The decline in these rates previously surpassed the decreases for all industries (Figures 5 and 6). In years when the Department of Labor [Bureau of Labor Statistics (BLS)] didn't calculate a DART figure for all industries (no report, indicating no change), the long-term care sectors' rates continued their drop.

The 2016-17 data show subsiding safety gains, however, as the sectors' rates did not fall at a pace greater than those for all industries. Each of the two long-term care sectors depicted still has a TRIR twice that of all businesses and DART rates in the 2.5x range. In the public sector[12], the nursing and residential care TRIR and DART are triple the private company rate.

11 "Crossing the Line: Navigating PDPM Therapy Rate Contracting," BKD CPAs and Advisors, March 14, 2019
12 Incidence rates of total nonfatal occupational injury and illness cases by industry and case types, 2013-2017, U.S. Bureau of Labor Statistics

Because so many injuries occur during lifting, transporting, and repositioning of patients, specialized equipment and protocols are needed to stem the tide. Moving residents to and from bed, assisting with bathing and positioning patients in chairs can cause micro-injuries to the spine and trigger moderate to severe musculoskeletal disorders.

"Lift teams" can be deployed to perform these tasks but employees too often decide when they are needed; a single worker might believe a team is not needed for a task because the individual feels capable of handling it alone. Mechanical lift-assist devices can be used but require capital outlay.

Hires must be evaluated thoroughly to maximize management's confidence they will perform tasks with patient and employee safety in mind. To minimize the chance of handling patients improperly, on-the-job training in patient handling protocols needs to be supplemented with follow-up instruction. Managers must oversee employees when lifting or transporting patients and adhering to OSHA regulations and guidelines.

Effort also should be dedicated to reducing or eliminating slip and fall hazards through employee awareness and facility maintenance programs.

Workers' Comp Impacts

Controlling workers' compensation costs is difficult when a facility has an extensive loss history (usually one year) of filed, paid, and expected-to-be-paid claims. Another factor is a high experience modification rate ("mod" or "e- mod"), which relates to the number and severity of claims filed. Insurance companies use this rate to gauge past injuries and potential risk to predict future losses and calculate workers' comp premiums.[13]

A return-to-work program can reduce future losses but getting employees back to work after an injury can be challenging. This can decrease the overall cost of claims; without it, employees can sit at home too long, making them less likely to return. Providing "transitional duty" means adjusting employees' responsibilities temporarily as prescribed by a doctor so they can heal properly. Patient-lifting is usually out of the question; less strenuous tasks need to be combined to keep the injured employee busy. These include passing ice and water, answering calls, taking vital signs or performing desk duty.

Lack of attention to accident and injury reporting procedures raises the risk of costly, time-consuming claims and lawsuits. Employees should not delay their reporting of any accident, whether it causes an injury or not. Incidents need to be documented immediately, with injuries or questionable accidents reported to the insurer within 24 hours.

Management Time Must Be Devoted

In addition to overseeing patient care and performing administrative functions, most managers need to implement safety practices. Someone needs to be designated the facility's Safety Officer, responsible for chairing a Safety Committee, reviewing existing safety policies and developing new ones and staying up to date on laws and regulations[14].

Department managers need to perform daily safety inspections of their areas using a checklist to assure consistency. Campus grounds and parking areas are to be included, as many incidents result from unsafe conditions in these areas. Scheduled reviews of all patient care and office areas by a Safety Committee sub-group allows the organization to determine if safety policies and processes are being practiced correctly and effectively.

A Safety Committee needs multidisciplinary representation from all departments and business locations: administration, facilities, resident care areas, housekeeping, infection control and dietary. Representatives from these disciplines dedicate time to implementing these committee best practices:

- Meetings held at least every other month including standing agenda items
- Encouraged participation from all members
- Meeting minutes maintained in writing
- Documented follow-up of all identified problems until resolution
- Education

13 Dumke, Gerry, " How Long-Term Care Facilities Can Reduce Their Workers' Compensation Claims," Caitlin-Morgan, October 24, 2018
14 Norman, Betty, "Playing it Safe: The Need for a Comprehensive Safety Program," PSA Financial, December 27, 2017

Rapt Attention to Injuries

The 2017 success of RiverSpring Health[15] testifies to the need to enhance processes. Staff rolled out a "Post Injury Management" function created by a "Workers' Compensation Design Team." Department heads, union delegates, a workers' compensation carrier representative and line staff partnered to redesign the existing process.

The program includes providing transportation to an urgent care center, where appropriate, with which the facility has established a relationship. The injured employee's supervisor accompanies the employee to and from the urgent care center. Supervisors call these employees on a regular basis to find out how they are feeling, let them know they are missed, and ensure connection until returning to work.

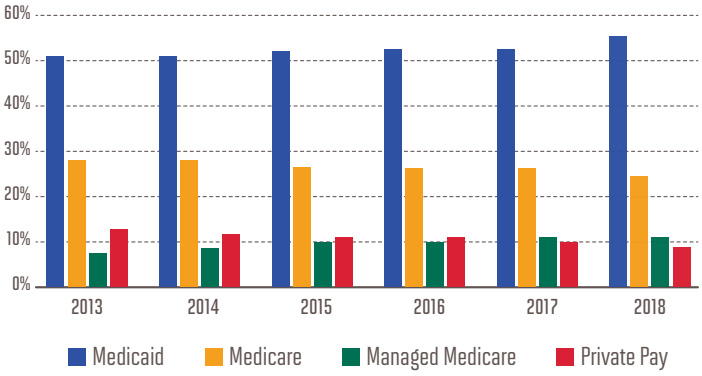
In revamping return-to-work procedures, management created 27 transitional tasks; injured employees who lost time from work are down 26 percent. Such results are encouraging but must be tempered: why haven't more facilities developed the focus, training and resources to properly respond to injuries? Perhaps it's heavy pressure to increase care productivity in a high-risk work environment.

Factor 4: Threatened Revenue Sources

Figure 7 portrays the importance of skilled nursing facility (SNF) revenue sources relative to each other:

- Medicaid, most important, becoming more important
- Medicare fee-for-service (FFS), next most, decreasing as Managed Medicare increases
- Private Pay, least important, decreasing

Figure 7—Skilled Nursing Revenue Source Mix



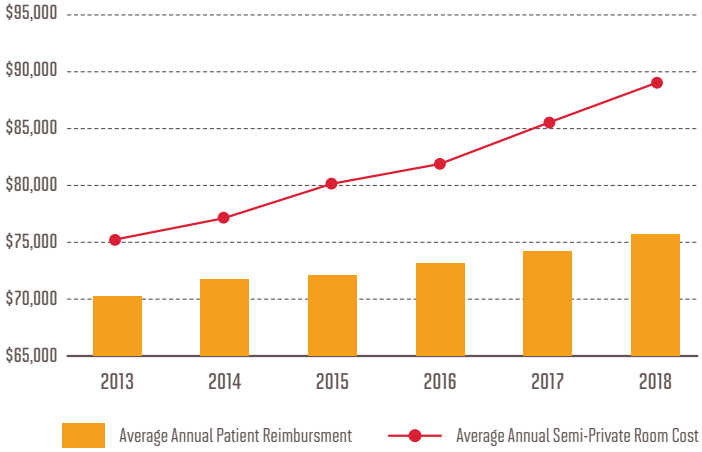
Source: National Investment Center for Seniors Housing and Care

As the investment analyst Zacks observes[16], each of these payers needs to contain reimbursement rates. The negative impact on skilled nursing profitability is compounded by the shift from traditional fee-for-service Medicare patients to Managed Medicare. More recently, challenges and complexities with respect to billings and collections have emerged with the onset of Managed Medicaid.

Medicaid: Politically Vulnerable

Figure 8 shows that for the past six years, the total annual cost of a semi-private room (red line) couldn't be covered with Medicaid reimbursement (orange bars). Medicaid patients have needed other sources to pay their long-term care bills. For many of those emerging from hospital care into skilled nursing, Medicare has been critical; Private Pay has played a role as well. Five years ago, these secondary sources covered all but $5,000 of average annual costs; today it's closer to $15,000.

Figure 8—Medicaid: Covering Less of a Year's Cost



Source: National Investment Center (NIC), Genworth Financial

15 Burke, Ellen, "A Worker's Compensation Success Story," *McKnight's Long-Term Care News*, March 3, 2017

16 "Nursing Home Industry Should Thrive on Aging Population," January 22, 2019, Zacks Equity Research, https://www.zacks.com/commentary/207048/nursing-home-industry-should-thrive-on-aging-population

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In a 2018 report, the Kaiser Family Foundation (KFF) called federal fiscal year 2019 "a year to watch how Medicaid's role evolves on the ground in the 50 states and D.C."[17] If Affordable Care Act (ACA) reform gains momentum, Congress could cap Medicaid financing in adjusting ACA.

In 2017, an effort in Congress to significantly overhaul the way the federal government funds Medicaid as part of ACA reform would have gutted around $800 billion from the program over the next decade. While that measure failed, it could recur in the proper political climate.

KFF noted that while the federal government funds Medicaid, states have final say over the way funds are disbursed. Multiple states declined to pursue Medicaid expansion efforts as allowed under the ACA.

State legislatures also play a role in the development of Section 1115 waivers, or special exemptions to Medicaid rules that state governments can use to explore new care models that could reduce costs while improving care. "State-level gubernatorial and legislative elections could have implications for states considering Medicaid expansion or Section 1115 demonstration waivers," KFF concluded.

Medicare: Question of Solvency

A February 2019 report issued by the Centers for Medicare and Medicaid Services (CMS)[18] projected national health expenditure growth at 5.5 percent annually from 2018 to 2027. As a result of comparatively higher projected enrollment growth in Medicare, average annual spending growth in Medicare (7.4 percent) is expected to exceed that of Medicaid (5.5 percent) and private health insurance (4.8 percent).

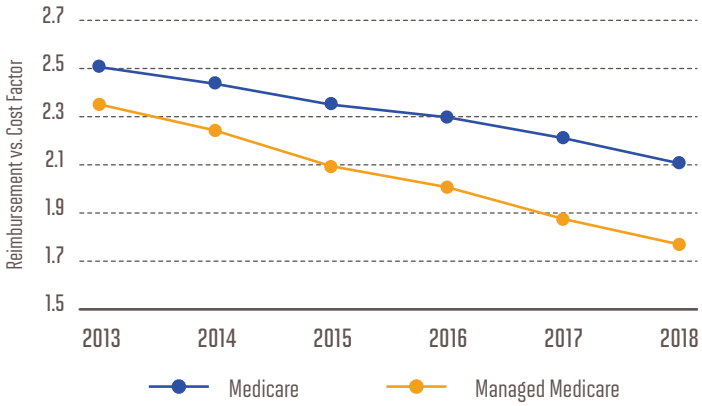
The Congressional Budget Office (CBO)[19] predicted that Medicare spending would double from $708 billion in 2017 to $1.4 trillion by 2027. If that is the case, Medicare will be the biggest driver of federal health care spending—larger than Medicaid, the Children's Health Insurance Program (CHIP) and the ACA.

Medicare's Hospital Insurance (HI) Trust Fund fills gaps in payments made from Medicare operating funds for skilled nursing facility and home health services following hospital stays and hospice care. Medicare trustees project that the trust will be depleted in 2026. It's anticipated that operating funds will be sufficient to pay 89 percent of costs at that time—but political and economic conditions could cause that to fall short.

The trustees project that the share of HI cost that can be financed with HI dedicated revenues will decline slowly to 77 percent in 2046 and rise gradually to 83 percent in 2093. "The HI fund again fails the test of short-range financial adequacy, as its trust fund ratio is already below 100 percent of annual costs and is expected to decline continuously until reserve depletion in 2026," they conclude.

Figure 9 demonstrates the failure of Medicare and Managed Medicare reimbursements to keep pace with the rising costs of a semi-private skilled nursing room. The values in this chart compare these reimbursements with room costs on an annual basis. This figure is always higher than the average room cost because Medicare covers only procedure-intensive days following hospitalization, which are always more costly than the average. How much higher is this metric? Not as high as it used to be and steadily less compared with the rising cost.

Figure 9—Medicare: Not Keeping Pace with Costs



Source: National Investment Center (NIC), Genworth Financial

Private Pay: Rise Sputters

The National Investment Center for Seniors Housing & Care (NIC) reported[20] that private revenue per patient day (RPPD) was relatively flat from the third quarter to the fourth quarter of 2018. It continued to be range-bound in the previous few months but had declined since February

17 "2019 Will Be a Year to Watch for Medicaid as Long-Term Care Drives Spending," *Skilled Nursing News*, Oct. 25, 2018
18 National Health Expenditure Projections, 2018-2027, Center for Medicare & Medicaid Services, February 2019
19 Congressional Budget Office, Health Care, https://www.cbo.gov/topics/health-care
20 *Skilled Nursing Data Report, Key Occupancy & Revenue Trends*, National Investment Center for Seniors Housing & Care, 4th Quarter 2018

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2018. "This is notable because it has steadily increased over the past few years," NIC concluded.

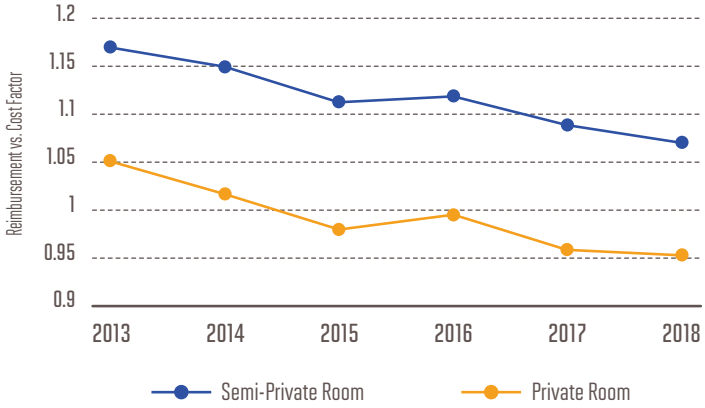
However, recent data suggested a slowdown compared with last year. Whereas private pay revenue per patient day (RPPD) did grow at 1.7% compared to the year before in December 2017, it has been oscillating around the $262 range for several months. Private RPPD decreased the most in rural areas representing a quarterly decrease of 1%. It was relatively steady in both urban and urban cluster areas.

Zack's points out the importance of nursing homes' contact with private insurers and managed care organizations for patients. Ongoing consolidation in this space has reduced the number of players, thus thinning the supplier base for the nursing home industry. That has decreased price competition, forcing providers to offer lower rates to these payers.

Moreover, a dearth of insurance policies that provide long-term care insurance has kept patients away from nursing homes.

Even though the sum of all private payments has risen at times, it hasn't been enough to keep pace with its traditional importance in covering patient costs. Figure 4 shows the degree to which private pay is falling behind cost increases for skilled care. As in Figure 9, the comparison shows how a payer's reimbursement compares with the increasing cost of a room, although in this case, the chart reflects both private and semi-private room costs. Private pay per room has traditionally been higher than the cost per room because previously this type of reimbursement has covered the majority of costs for a higher percentage of patients as well as some costs for others. The declines reflect the industry's increasing reliance on public pay.

Figure 10—Private Pay: Decreasing Influence



Source: National Investment Center (NIC), Genworth Financial

Factor 5: Laundry Outsourcing Benefits

Considering the investment of time and money needed for long-term care providers to cope with reimbursement, wages, regulation and safety, opportunities to save time and money that improve or maintain effective patient care warrant investigation. Outsourcing linen and laundry presents one such opportunity. The time is right for providers to take greater advantage of linen services, whose interest in serving the long-term care market has never been greater.

This paper is part of a 2019 TRSA campaign to build awareness of the favorable economics to long-term care providers of such outsourcing. The campaign's advertising and collateral prompt use of a TRSA web utility (**www.trsa.org/oplsavings**) that calculates potential annual savings, according to a facility's number of beds, from shutting down an OPL in favor of using a linen service. In recent years, such savings have been well into the double digits in percentage.

To healthcare facilities, linen services either *rent* textiles (mostly bed and bath linen, uniforms and garments), laundering, maintaining and delivering them; or these services *process* customer-owned goods (COG); or both. Typical laundry operating costs are categorized as:

- Plant
- Sales
- Delivery
- General/Administrative

TRSA's calculation of cost savings from outsourcing is based on annual reports in 2016 of 214 nursing homes in Connecticut to the state. These facilities have from 40 to 532 beds with laundry expenses accordingly ranging from about $5,000 to $800,000. Factoring in allocations to laundry for expenses paid for the facility as a whole, such as electricity, gas, water, sewer, maintenance, insurance, and other types of costs (administrative, payroll tax, etc.) revealed higher costs per pound for OPLs. This computation provided the basis for the TRSA web utility that that calculates potential annual savings from outsourcing.

An earlier survey comparing costs per pound of laundry borne by outsourced rental and COG operations versus self-operated long-term care facility laundries[21] reveals the cost differential. The latter have no sales expense and minimal delivery (linen distribution) expense; still, they spend 9 percent more per laundry pound produced than rental laundries. This survey also indicates that long-term care OPLs receive only about 80 percent of the funding they need to operate. Because other budgets have to cover the shortfall, the true cost per pound is about 25 percent more than rental.

COG operations have no merchandise cost, which the survey indicates is about 11 percent of a long-term care OPL's expenses. Add that cost to what's paid for COG service and savings would still be 17 percent of budget to use COG. Factor in the funding shortfall covered by other budgets and savings approach the 30 percent level.

These figures don't translate dollar-for-dollar to price savings for most long-term care facilities. Rental and COG laundries are for-profit businesses, so their margin is factored in their pricing. Also, their performance data here applies to their costs for serving all healthcare customers, including hospitals. Those facilities produce economies for outsourced laundries that diminish overall costs per pound for COG and rental. Such costs of serving long-term care facilities (lower volume) are higher.

Mostly OPL shutdown positively affects the bottom line thanks to decreased plant (laundry production) costs, which account for 80 percent of the budget compared with 20 percent for merchandise, delivery (including linen distribution) and administration combined. Table 6 reflects COG and rental operators' lower cost per pound experience for laundry production budget line items compared with these expenses in OPLs. The expense lines are listed in descending order of cost to OPLs.

Table 6. OPL vs. Outsourcing: Cost Savings by Expense Type

Expense Line Item	Percent of OPL Plant Budget	Cost Per Laundry Pound Percent Difference ($)	
		COG	Rental
Plant Production Labor - Wages	38.08%	-40%	-37%
Plant Employee Benefits	11.41%	-40%	-34%
Plant Fuel - Natural Gas	10.70%	-35%	-40%
Plant Power - Electricity	7.54%	-47%	-45%
Plant Supervision - Wages	5.88%	-60%	-54%
Production Supplies - Chemicals	5.88%	-49%	-41%
Depreciation - Building	4.67%	-86%	-86%
Equipment Maintenance Cost	4.67%	-58%	-57%
Plant Water - Water & Sewer	4.14%	-24%	-25%
Building Maintenance Cost	2.23%	-86%	-87%
Maintenance and Power Plant - Wages	1.73%	75%	91%
Outside Processing Cost	1.64%	-40%	-31%
Property and Casualty Insurance	1.21%	-79%	-81%
Depreciation - Equipment	0.20%	2289%	1267%
Plant Production Supplies - Maintenance	0.02%	140%	165%
	100%		

Source: Philips and Associates

Thus, the survey shows outsourced laundries spend 34 percent to 40 percent less per pound on the most costly items in OPL laundry production budgets: plant labor wages, employee benefits and natural gas. These account for 60 percent of all OPL laundry production expenses—nearly half of all OPL expenses. COG and rental operations spend exponentially more per pound than OPLs on their smallest laundry production expenses:

21 2008-2009 North American Edition Comparative Operating Revenues and Expense Profile for the Healthcare Textile Maintenance Industry, Phillips & Associates, Minneapolis, September 15, 2010

equipment depreciation and maintenance supplies. Are OPLs adequately tracking those expenses?

Safety as Prime Concern

The most expensive laundry production line item, plant wages, represents a small percentage of nursing and residential care facility employees[22]. But that figure doesn't reflect benefits cost, the second most expensive laundry production line item. Laundry injuries can mar workers' comp loss history and a facility's mod rate. Such complications factor into the decision to shut down an OPL.

Environmental services contractor Healthcare Services Group notes the possibility of dryer fires[23]. Most of these in long-term care facilities stem from a failure to adequately clean lint filters or by drying mops or rags that, even when washed, still contain grease from cleanups and ignite in the confined and heated space of a dryer drum.

Laundry work exposes employees to the ever-increasing range of contaminants and infectious materials in linen that comes from units to the OPL, highlighting the need for effective infection control procedures. Improper collection and transportation of soiled linen has always been a major risk and has become an even bigger issue in recent times.

It can be a challenge to follow collection, sorting, washing and storage procedures. They can expose employees, residents and visitors to hazards. Isolating soiled from clean linen must take place in the room where soiled is collected and handled with a minimum of agitation to prevent spreading pathogens between items. "Even with the rise of 'super bug' publicity, not enough attention is paid to how soiled linen is gathered and transported," a representative of a laundry chemical supplier commented.

Exposure to such chemicals represents another risk. Another such supplier observed, "In a properly installed laundry room, an employee's exposure to chemicals should be at a minimum; however, there will still be some chemicals onsite that can be hazardous when misused or mixed improperly." Absence of safeguards and procedures to avoid these mistakes and improper soiled linen handling could foster higher worker absenteeism from an increase in sick days as well as more comp claims.

Lockout/tagout rules for machine maintenance are more likely to be overlooked when this function isn't the responsibility of a full-time engineering/maintenance person. Such discharge of hazardous energy from automated systems threatens worker death or serious injury, portending OSHA fines and large lawsuit settlements.

Manifestation of Workforce Issues

Laundry epitomizes the perils of the contemporary workplace. Safe, successful performance is more difficult as work volume grows and productivity needs to rise. In today's buyer's market for labor, workers are inclined to find new opportunities. Competitive pressure to reduce business costs is growing, requiring many organizations to accomplish more with fewer people or resources.

Employees are looking for shortcuts. In trying to get things done faster to relieve an overburdened system, they can adopt bad practices. Such missteps are made from ignorance or misunderstanding of the importance of the task at hand. They highlight the need to provide training not only on how to do things, but why things need to be done a certain way. More time must be devoted to educate employees about procedures, train them on how to perform these properly, actively monitor them, retrain those who aren't compliant and penalize those who continue to ignore their training.

This means organizing the laundry process, scheduling it properly and supervising it regularly. OPL staff knows their main goal is to get the linen needed for the next shift processed before their shift ends. They can't be left on their own to find ways to produce what linen is needed by the next nursing shift.

Shutting down the OPL is the simplest way to avoid this problem and achieve the corresponding economic gain. You eliminate one persistent management challenge (operating an OPL safely and efficiently) that gives you more time to address heavy burdens that require consistent attention:

22 Employment by industry, occupation, and percent distribution, 2016-2026, Nursing and residential care facilities, U.S. Bureau of Labor Statistics
23 "Laundry Duty Hazards," *McKnight's Long Term Care News*, August 2, 2011

- Navigating the reimbursement maze, with revenue sources shrinking and reimbursement formulas changing
- Contending with high labor costs, in light of minimum wage increases boosting the pay of a vast majority of the workforce
- Complying with new regulations aimed at ensuring a higher level of resident care by prompting greater attention to quality assurance and infection prevention
- Reducing a wider variety of risks to continue to substantially increase workplace safety and prevent increases in already-high workers compensation premiums

It's no longer worth the effort to operate an OPL each day. Your management team needs more time to develop strategies and implement tactics to address the obstacles described above. Leave laundry to an offsite contractor invested in performing this function properly and ready to take it off your hands. Go to **www.trsa.org/oplsavings** to get started.

Hygienically Clean Healthcare certification acknowledges outsourced laundries' effectiveness through inspections that scrutinize laundry quality control procedures related to the handling of textiles containing blood and other potentially infectious materials. Quarterly microbial testing ensures that as conditions change, such as water quality, textile fabric composition and wash chemistry, finished product quality is consistently maintained.