New England
ADMINISTRATOR

June
2021

"Whenever you find yourself on the side of the majority, it is time to pause and reflect."
-Mark Twain

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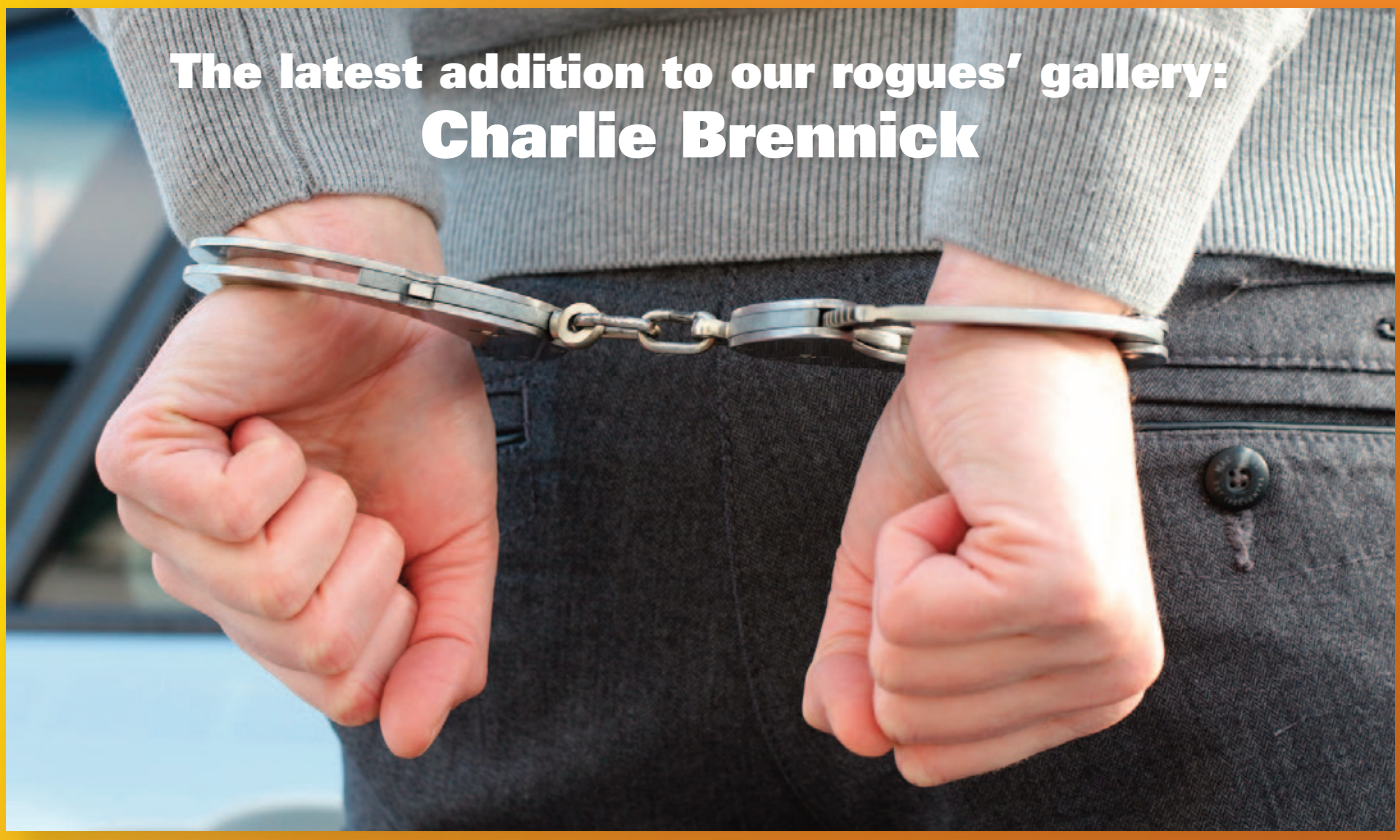

The latest addition to our rogues' gallery: Charlie Brennick

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COVID-19 1135 waivers

by Kris Mastrangelo, OTR/L, MBA, LNHA

CMS issued a memo announcing it is ending four of the 1135 waivers issued in response to the COVID-19 Public Health Emergency (PHE). These changes are effective May 10, 2021.

The four waivers that will be ending are related to:

- Prior notification of room and roommate change,
- Prior notice of transfer/discharge,
- Certain care planning requirements and
- MDS submission.

CMS also provided clarification and recommendations for Nurse Aide Training and Competency Evaluation Programs (NATCEPs). Currently, CMS is keeping the current nurse aide waiver.

The following changes are effective May 10, 2021.

Resident Roommates and Grouping

- No more waiver for notification before Resident Room or Roommate Change at 42 CFR §483.10(e)(6).
- Remains a waiver: 42 CFR 483.10(e)(5) and (7) when a change of rooms is done solely for purposes of cohorting due to COVID-19.
- Action: Provide notice before a room or roommate change except when the change is solely for COVID-19 cohorting.

Kris Mastrangelo

Resident Transfer and Discharge

- No more waiver for Waiver of notification before Transfer and Discharge at 42 CFR §483.15(c)(4)(ii)
- Remains a waiver: Related waivers at 42 CFR 483.10(c)(5) as well as 483.15(c)(3), (c)(5)(i) and (iv) and (c)(9), and (d) that allow providers to transfer or discharge residents to another long term care facility solely for cohorting purposes without prior written notice.
- Action: The facility must provide written notice of transfer or discharge at least 30 days in advance, or as soon as practicable in certain situations, before the transfer or discharge.

Care Planning Requirements

- No more waiver for certain care planning requirements at §483.21(a)(1)(i), (a)(2)(i), and (b)(2)(i) for residents transferred or discharged for cohorting purposes.
- Action: The facility must complete baseline care plans within 48 hours of admission and comprehensive care plans within seven days of completion of the comprehensive assessment, according to current regulations.

Minimum Data Set (MDS)

- No more waiver for waiver of timeframe requirements for complet-

Continued on page 18

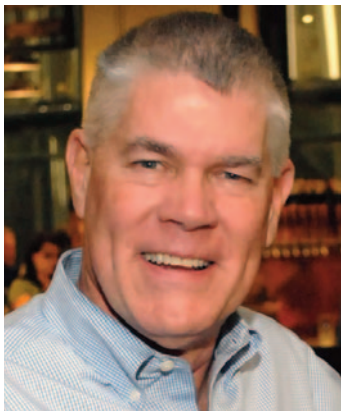
ACHCA's Bill McGinley retires

by Bruce Glass, FACHCA,CNHA, CALA,

On March 15, Bill McGinley, president and CEO of the American College of Healthcare Administrators announced his retirement after four years leading the professional association.

Bill assumed the position at a time when the organization was recovering from a difficult period, and directed a strong recovery, helping to increase the membership and industry profile. Bill was especially proud of the close partnership developed with other industry groups, including AHCA, APAACN, NAHCA, and AMDA as all battled the ongoing pandemic.

Bill's career spanned 41 years, including 39 years as an ACHCA member where he held numerous positions before assuming the national leadership. His extensive experience



Bill McGinley

as both a nursing home and assisted living administrator gave him a unique advantage when he stepped into the leadership of ACHCA.

The immense respect he enjoys with his peers was summed up by ACHCA Board Chair Bob Lane: "Over the

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Post-pandemic marketing... REALLY?

by Irving L. Stackpole, RRT, MEd

SINCE THE PUBLIC HEALTH EMERGENCY WAS DECLARED IN THE US ON FEBRUARY 3, 2020, THE CONSEQUENCES ON NURSING HOMES AND ASSISTED LIVING HAVE BEEN SEVERE.

As we try to emerge, those of us in congregate care are beginning to have patients/residents trickle back into our buildings. A sense of relief can be felt coast to coast. The "pressure" seems to be relieved, and we're back to doing what we've done for decades. The flood of federal funds has kept the bankruptcies at bay.

Since the test positivity, hospitalization and death rates have declined in many areas and vaccinations have increased, we need to face some facts. My purpose here is not to be depressing but to offer a sober look at some facts which I pray will offer a reliable way to plan.

We aren't going to get to herd immunity

Despite what the popular press and political pundits are saying, it's highly unlikely that the United States will achieve 70% full vaccination among the population. Moreover, "herd immunity" will be a political hot potato and used by certain media to further disparage public health initiatives.

Irving L. Stackpole

The public is having, and will continued to have difficulty grasping shifting, elusive goals and behavioral standards. Pandemic exhaustion will be widespread, and healthcare providers, which are trying to protect their residents and staff, may come to be seen as actors in a theater of the absurd. Marketing tip: Be prepared to explain infection control and containment procedures at an 8th grade level.

This is relevant from a marketing point of view, especially in the direct-to-consumer channels because long-term care providers will be forced to both mitigate fear and appear balanced and reasonable in their policies.

Referral recovery will be irregular

Referrals from other healthcare professionals/organizations (B2B) will be fewer and much more selective/concentrated. Market share will become very difficult to shift away from downstream LTC providers which establish themselves as preferred destinations within risk-bearing networks. The corollary opportunity of this market shift will be to those SNF/IRF/LTACH/HHA providers which take their data, go to hospitals and the medical groups in their marketplace areas, and bludgeon them into submission.

This may not seem like a marketing point of view, but the decision-makers in our marketplace areas know they need congregate long-term care providers, but they have no idea how to speak our language. As I have urged many times before, it is up to us to learn how to speak their language and to use all the data we have been collecting to show hospitals and doctors why Mrs. Jones should not go home but should rather be admitted for five days of rehabilitation. If you can't prove this, why do you exist?

Choice-based congregate care providers such as age-qualified independent living, board & care, and assisted living will be faced with a slightly different set of challenges. In many marketplace areas, independent living and assisted living providers did not suffer the same PR nightmares as did nursing homes. The result will be a renewal of interest and return of move-ins. Many independent living providers didn't suffer the same loss of occupancy as other types. The challenge for these choice-based congregate providers will be the progressive medicalization of their populations.

Aided by increased penetration of Medicare Part C Plans (Medicare Advantage or MA), we will truly see what had been talked about for years: that assisted living will begin to look like nursing homes. As more and more of the population is covered by MA and providers enjoy what amounts to a federal subsidy, this market will further stratify, but this is a story for another day.

Downstream long-term care providers who are unable to find a seat at the risk-bearing table may survive in certain marketplace areas, but overall the casualties will be from 5% to 12%. Once the federal stimulus dries up, my estimates are that 780 to as many as 2,000 nursing centers will go bankrupt or close, and there could be more. (This is not a typographical error.)

In the direct to consumer (D2C) markets, the timeline and rate of recovery will be based on:

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Playing with house money

by Edison Beaumont

In the mid-1970's, a man carrying suitcases full of $100 bills checked into a hotel along the Las Vegas strip.

His New England-based nursing home business was failing, and he had a plan. The man's name was Charles Brennick.

During this trip to Vegas, and on other subsequent visits, Brennick would stuff his luggage with cash, confident that he could gamble his way out of the red and into the black. He glad-handed his way around the hotel and the adjacent casinos, leaving lavish tips for the waitstaff and dealers, as high rollers were expected to do.

Around the same time, in a book called "Tender Loving Greed," author Mary Adelaide Mendelson introduced readers to Mr. Brennick. In fact, she devoted several pages to his checkered past and shady misdeeds while running his company, Medico.

Sources indicate that Charles Brennick lost $7 million at the tables in Las Vegas, but neither this, nor the notoriety that he gained from Mendelson's book would derail the man who built a profitable but dubious enterprise, earning him a membership in our gallery of rogues.

After his gambling strategy turned into a colossal failure, Brennick filed for chapter 11, recasting his organization by adding "New" to the Medico name. By closely following the successful lead of the Greenery Rehabilitation Group, Inc., an organization founded and operated by his cousin, Gerald Martin, New Medico grew to over 40 facilities at its peak.

By all accounts, Mr. Martin built a highly effective team of innovators that included, among others, the immediate past President and CEO of ACHCA, Bill McGinley, as well as George Ferencik, an administrator who pioneered the first neuro-rehab program for brain-injured patients, and later served as president of the Greenery Group.

As Martin's organization garnered well-deserved accolades and recognition, Brennick's New Medico attracted attention for all the wrong reasons, such as risky business decisions, legal troubles, regulatory problems, allegations of fraud, abuse, sexual assault, falsified records, medical negligence, and unethical marketing. Somehow, he survived.

Copying his cousin's model for brain-injury care and treatment, Brennick capitalized on providing specialized long-term care for a patient population that is reimbursed at far greater rates by Medicaid than custodial care for elders at his nursing homes.

Brennick converted his vacation home in New Hampshire, and opened it as Highwatch Rehabilitation Center, (later renamed Lakeview NeuroRehabilitation Center.) For this level of care, Brennick could charge ten times the amount for rehabilitation than was being paid to nursing homes for the same service. The result was a substantial profit, and a business model that he expanded quickly to other locations.

Only the best people

Charles Brennick had just a sixth-grade education. He made decisions based on gut instinct while following the lead of his cousin, Gerald Martin's business, and he hired people who he felt were leading experts in their field. Some, like attorney Barry Portnoy, made a fortune helping Brennick reorganize his businesses. Attorney Portnoy founded the publicly traded Health and Retirement Properties Trust to finance Brennick's expanding empire.

Brennick sold a stake of 9.9% of his company to his trusted attorney for just $130,000 of Portnoy's own money. Thirty months later, Portnoy sold it back for more than $6.8 million. (If you're wondering about the 9.9% number, a 10% sale would trigger a regulatory investigation.)

Years later, while on his deathbed, Charles Brennick attempted to sue his former attorney, for hundreds of millions of dollars in damages.

The brain trust at New Medico learned that Medicaid would pay more if the patient required specialty care in another state. So began the practice of admitting brain-injured patients across state lines, even if a New Medico facility existed in the geographic proximity of the patient. At one time, 400 New Yorkers were being treated out of state for brain injuries, at a staggering cost of millions of dollars. New Medico was operating neuro-rehabilitation centers within New York at the time, but for whatever reason, were unable to accommodate local patients.

Brennick's leadership team also took advantage of loopholes to license brain rehab centers as transitional care facilities in some states, which are not subject to the same intense scrutiny that nursing homes regularly and repeatedly endure. As such, federal and state regulators did little or nothing to address the growing tidal wave of complaints of abuse and mistreatment.

In 1988, Brennick was arrested in MA after he was observed having sex with a prostitute in his car. As the police put him in handcuffs, he passed $3,000 to them and asked if they could simply forget about the

Continued on next page

Greenery, a unique facility, was a training ground for many administrators

by Bill McGinley

Among the casualties of the nursing home crisis in Massachusetts was the Greenery Rehabilitation and Skilled Nursing Center in Brighton. Greenery discharged its last patient and closed the doors at the end of November 2001.

In its heyday, Greenery provided some of the most complex care ever in a skilled nursing facility. Opened in 1971, its first two administrators were Don Buckley and Paul Simeon. In October 1972, George Ferencik became the administrator and was associated with the facility until 1993. It was under his leadership that Greenery developed its world-famous head injury rehabilitation programs.

George identified the need to serve a type of patient who was being discharged from local hospitals who required a level care not found in the typical nursing home of that era. These patients required sophisticated nursing and recuperative and rehabilitative services not generally available outside of the acute hospital setting.

In 1972, preceding the establishment of the three major rehabilitation hospitals that today serve the greater Boston area, George certified a forty-bed unit for participation in the Medicare program. The following year that unit admitted more than 400 patients, successfully discharging 398 to their homes. The rehabilitation experience, gained primarily in the care of stroke and orthopedic patients led Greenery to develop specialty services for neurologically impaired patients. Responding to the demands of hospital discharge planners, Greenery became the treatment facility of choice for patients who needed neurological rehabilitation.

By 1978, Greenery was admitting only patients who had suffered traumatic brain injury. The facility, staffed with its own PT, OT, speech, and respiratory therapists, provided intensive rehabilitation and skilled nursing services.

To ensure a true interdisciplinary process, the facility established a case management department. Staffed by non-direct care nursing and rehabilitation professionals, the department coordinated the services delivered to each patient in a way that responded to the needs of the patient, the family, and the third-party payer. This was years ahead of the concept that we today know as managed care.

Greenery developed an international reputation for the care of head injured patients.

By 1980, Greenery, now renamed the Greenery Rehabilitation and Skilled Nursing Center, had developed an international reputation for the care of head injured patients. The facility had specialized units caring for patients at various levels of cognitive awareness. With two 40-bed units caring for coma patients, one unit for higher-level rehabilitation patients, and specialty units for behavioral and cognitive rehabilitation as well as ventilator support services, Greenery was the largest program of its kind in the world.

Greenery initiated innovative financing for the payers of catastrophic care by developing all-inclusive per diem rates. This simplified the claims management for the payer agencies while allowing clinicians to provide services to each patient without regard to reimbursement.

Greenery was first accredited by the JCAHO in 1976. In 1981 Greenery was accredited by the Commission for the Accreditation of Rehabilitation Facilities (CARF) under the comprehensive inpatient rehabilitation standards. Greenery was the first skilled nursing facility to be accredited under these standards, which were written for rehabilitation hospitals. Today, CARF, recognizing alternative treatment sites, has separate standards for skilled nursing facility-based subacute units.

Consider these additional examples of complexity and uniqueness:

- First comprehensive inpatient brain injury rehabilitation program in a skilled nursing center.
- Patients from 44 states

Continued on next page

Rogue: Medico's Charles Brennick

Continued from preceding page

arrest. Police found $26,000 in cash in his car. Inexplicably, the charges were soon dropped.

In 1990, a congressional investigation began, focusing on New Medico and similar neuro-rehab centers. It was learned that New Medico facilities were charging patients up to $30,000 per month for services, while promising miracles to emotionally vulnerable families, and discharging patients as soon as their funding source dried up, regardless of their condition. One former staff psychologist called the operation "a high-priced homeless shelter."

Charles Brennick's son, Joseph, while employed as part of his father's senior leadership team, issued a hand-written memo to department heads demanding that they prevent people from discharging while they were eligible to be billed, proving that rotten apples don't fall far from the tree.

Based on the congressional investigation, the FBI raided New Medico's home office In Lynn, MA, in 1992, seizing 750 boxes of incriminating documents. Brennick was not indicted, however, and he began selling off his buildings.

His son, Joseph, was installed as the owner/operator of the Florida Institute of Neurologic Rehabilitation. Following a Bloomberg investigation of widespread patient abuse at FINR, All-State insurance sued for $7.6 million in fraudulent billing claims. One year later, Joseph Brennick filed for bankruptcy on behalf of his facility.

Charles Brennick died in 1997, but his past continues to cast a pall over our profession. For those who wonder why nursing homes are vilified by the government and media and have devolved into the most heavily regulated business in the country, and for every parent who has demanded that their adult children promise they will never, ever put them in a nursing home, we wear a thorny crown because of bad actors like Charles Brennick. His legacy of greed outlives him, and his callousness to the plight of patients is egregious.

The lesson to be learned is that we cannot let the actions of rogues like Charles Brennick eclipse the efforts and intentions of thousands of ethical and caring administrators who work to make the world better for so many. For the good of our elders and staff, we must carry on.

Learned dependency and aging

by Sheldon Ornstein Ed.D, RN, LNHA

Several decades ago two prominent psychologists wondered whether giving institutionalized elderly people a tiny amount of control over something in their lives would have a positive influence on their personalities.

They gave a house plant to each resident in a nursing home. Half of the residents were told that the plants would be cared for by the nursing staff. The other half were told that they were responsible for the care of the plants. They were to decide when to water the plant and how much sun it should have. At the beginning of the study, the two groups were similar in physical and mental vigor. Three weeks later, there was no difference in the health of the plants, but there was a lot of difference in the psychological adjustment of the residents who were put in charge of caring for their plants. The group given personal responsibility rated themselves as more alert, active, and vigorous.

The take-home message is that feeling in control of some portion of their experience is good for elderly individuals' physical and mental health. The amount of governance people have over the events in their lives changes dramatically during their lifespans.

How then do we continue to have control in our lives as we age? One major way is to maintain a workable balance between independence and dependence. As we grow older we need to be wary of prematurely giving up governance of segments of our lives that we can still do successfully. This can happen because those who are concerned for the older person (i.e.: professionals, mature children, relatives, friends, etc.) may encourage dependency out of good intentions. They may take control over the various activities of living that the older person might still be capable of managing, but at a slower pace.

A classic study of learned dependence was discovered with nursing home staff, which can also be applied to aged community dwellers. Staff regularly "encourage" elderly residents to be dependent upon them for their personal hygiene. This is not surprising because staff/caregivers want to perform these duties as quickly as possible based on the number of residents assigned requiring care.

The trick then for the loved one and/or caregiver concerned with the elderly person is to recognize that even the most enfeebled needs some domain over which they have control.

Perhaps the sense of independence comes from having their opinions taken seriously. Having one's views respected can do wonders for the continued mental vigor of the individual. With this positive attitude going forward, remarkable gains in the quality of that older person's life ensures continued relevance.

As a final note, there also has to be a balance between being willing to accept or request help with activities that are no longer physically feasible or safe, and activities that are still doable.

The New England Alliance Conference Calendar

IN-PERSON CONFERENCES!

Fall Regional Conference
September 22 to 24, 2021
Portland Regency Hotel

Spring Regional Conference
May 25 to 27, 2022
Newport Harbor Hotel & Marina

For more details: thenealliance.org

Greenery was groundbreaking facility

Continued from preceding page

and 4 foreign countries.

- Over 110 patients on tube feedings.
- A ventilator unit with 12 patients.
- 28 physical therapists, 26 occupational therapists, 16 speech therapists, and 12 respiratory therapists on staff
- The first to utilize an all-inclusive per diem for ease of billing by insurance companies.
- First use of clinical evaluators to screen patients off-site to ensure accuracy of clinical information before admission.
- First physiatrist-directed rehabilitation program with fellows and residents rotating through the program.

Greg Karr was the first assistant administrator, followed by Ben Whalen and Richard Blomquist. Greg later served as the administrator from 1988 to 1994. When the Greenery became a public company in 1986, George Ferencik became the president of the company and Richard Blomquist became the administrator. Laurie Talarico started at the Greenery as a nurse's aide in 1977. She became an LPN, RN, served as the DON, did an AIT under George Ferencik and also served as administrator from 1986 to1988. Other Greenery administrators include David O'Loughlin, Walter Collins, Jim Brusstar, and Marilyn Martin.

Among the many administrators who did their AIT at Greenery: Bill McGinley (ACHCA President and CEO), Sally Rouses, Carl Anderson, Elizabeth Wheatley (Five Star Health Care), Joe Hugar, Jeannine Carroll, and Tom Brown.

Other currently licensed administrators who started their LTC career at Greenery in the Newton corporate office: Karla Fleming (Administrator - Armenian Home, Boston), Paul Mahoney, Christine Reilly, Maureen O'Neil and Joe Shola.

Bill McGinley is the recently retired president and CEO of the American College of Health Care Administrators.

Enhancing nursing home care: behavioral health education in R.I. nursing homes

Marianne Raimondo MS, MSW, LICSW, Ph.D.

Nursing homes are increasingly caring for residents with behavioral health disorders, including mental illness and substance use. Studies vary but estimates of the prevalence of mental illness among nursing home residents range from 65-91%, and in many cases they remain undiagnosed and untreated.

Substance use among older adults is a growing public health concern as the number of adults 50 years and older with substance use disorders is increasing. Older adults may become more sensitive to the effects of substance use as they age, and drug use may exacerbate or trigger the onset of chronic medical conditions. Further, older adults are more likely to be prescribed psychoactive medications, increasing the risk of non-medical substance use and dependence. This trend has major ramifications for care as residents with behavioral health problems may exhibit challenging behaviors which are harmful to themselves, other residents, and staff. Finally, mental illness and behavioral symptoms among nursing home residents are often associated with increased hospital utilization and poorer health outcomes.

Despite the increasing behavioral health needs of nursing home residents, the workforce has not kept pace, as most staff have not received behavioral health education. This is especially true for paraprofessionals. Front-line staff, such as CNAs, are often ill-equipped to provide appropriate care to residents with behavioral health problems, as they are only trained to focus on personal care and activities of daily living. Without adequate training in behavioral health, staff may act out of fear or frustration, leading to verbal or physical abuse rather than more resident centered approaches. This contributes to job stress and dissatisfaction, leading to higher rates of turnover in nursing homes.

Without adequate training in behavioral health, staff may act out of fear or frustration

In Rhode Island, the Institute Education in Health Care at Rhode Island College recognized this need for behavioral health education for nursing home staff, after listening to the concerns of nursing home administrators. The Institute, created in 2015, engages college faculty in health-related disciplines in the development and delivery of educational programs to serve the health care industry. Faculty from social work and psychology worked with a committee of health care providers to develop a 30-hour behavioral health certificate program specifically designed for front line, direct care staff working in healthcare organizations. While clinicians, including nurses and social workers, receive some education in behavioral health, paraprofessionals receive no formal education to prepare them for caring for residents with behavioral health needs.

The goals of the training were to: help participants understand the connection between physical and behavioral health, recognize the presentation of behavioral health disorders, and sensitize staff to the nature of behavioral health disorders. The training also develops the competencies and skills needed to care for residents struggling with mental illness or substance use and collaborate and communicate effectively with other members of the caregiving team. These skills include active listening, crisis management, de-escalation techniques, interpersonal communication, motivational interviewing, and self-reflection. The course content includes an introduction to common mental health disorders such as anxiety, trauma, schizophrenia, mood disorders, and others, including the signs and symptoms of these diagnoses, and an understanding of addiction and concepts of recovery. The training also provides an understanding of professional boundaries and ethics; the importance of culture and behavioral health disparities; and self-care. In addition, participants learn how to recognize and regulate their own unproductive biases or emotional states. At the conclusion of the training, participants prepare a presentation demonstrating how they have applied learning to a specific resident(s) they are caring for.

In Rhode Island, the training has been made possible by several grants from a variety of funders, including the Neighborhood Health Plan of RI, Healthcentric Advisors, and the Executive Office Health & Human Services. Evaluation of the training has revealed that participants gained a much better understanding of behavioral health and were able to translate this learning to their work setting. Participants have reported being much more confident caring for residents with behavioral health issues. As direct care staff in nursing homes also personally experience many life stressors, and may struggle with their own mental illness or substance use, they found the module on self-care especially helpful.

Participants learned techniques to help them cope with their own personal anxiety, depression, grief, or stress including breathing techniques, tapping, visual imagery, meditation, and prayer.

One of the greatest challenges encountered in rolling out this training had been freeing up staff to attend sessions during work time. Staff were enthusiastic about receiving the education and enjoyed the learning, but often attended sessions stressed about the workload they left behind without adequate coverage. Inadequate staff coverage often caused CNAs to miss sessions. To address this challenge various options were devised including make-up sessions, providing online learning, and offering the training at different times of the day. Leadership support for protecting staff time to attend training programs is essential for successful staff education.

The greatest attendance and completion rates were achieved when participants received stipends or pay increases for earning the certificate. This incentive absolutely contributed to staff engagement, commitment, and completion of the training. As CNAs and other direct support staff are the lowest paid workers, it is essential that they receive some increased compensation, whether a bonus, a stipend, or a pay bump when they pursue education and professional development.

While evaluations of the training indicated that participants learned a great deal about mental illness disorders, the physiology of addiction, the stages of change, and the stigma associated with behavioral health issues, what was so significant was the complete lack knowledge they had before attending the training. This raised the question: why do we entrust the care of residents with such complex physical and mental health needs to individuals who do not possess the knowledge or skills to care for these residents? Even more important, why do we compensate them so poorly? Another inter-

Continued on next page

Bruce Glass receives journalism award

The American College of Health Care Administrators (ACHCA) is proud to announce, W. Bruce Glass, CALA, CNHA, FACHCA of Rhode Island as the 2020 recipient of the Journalism Award. Recipients will be recognized during the ACHCA Convocation Virtual Experience (April 13 - 27, 2021).

This award recognizes an individual or organization for excellent journalistic achievement representing fair and accurate content related to the post-acute and aging services industry. Past Chapter President of Massachusetts and New Hampshire, Glass serves as Editor and Publisher of The New England Administrator, a quarterly digital magazine with information for New England senior care professionals. He developed the digital newsletter in 2019.

Bruce Glass

Glass ensures that articles published in the journal contribute to the integrity of the post-acute care industry. Information is informative, timely, and relevant to the practice of post-acute and aging services leadership. The New England Administrator has become the model district newsletter for ACHCA.

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Behavioral health education

Continued from preceding page

esting phenomenon that the training highlighted was the compassion displayed by direct care staff. For example, when topics of professional boundaries were discussed in training, CNAs acknowledged that they regularly violate boundaries by purchasing gifts for residents or even necessities such as bed linens, toiletries, and favorite food items for residents who have no loved ones to care for or cheer them. Once again, we ask: Why is it that we do not appreciate or recognize the compassion of our front line workers who are the backbone of our nursing homes?

There is a significant gap in the knowledge and skills of nursing home staff in providing care to a growing population of residents with behavioral health disorders. Training and education for the direct care workforce in nursing homes is paramount to the delivery of quality care and assuring the overall well -being of residents. Further, educating, elevating, and empowering CNAs and other frontline workers will also lead to increased employee satisfaction and joy in the workplace, and hopefully greater retention in nursing homes. Finally, improved care for residents with behavioral needs is a key factor as nursing homes consider participation in accountable care organization contracts, which require better management of hospital admissions/readmissions and improved health outcomes for residents.

For more information on the Behavioral Health Certificate program at the Institute Education in Healthcare, Rhode Island College contact the author at mraimondo@ric.edu

Marianne Raimondo is Associate Professor, Health Care Administration at Rhode Island College and Executive Director, Institute Education in Health Care

Have you ever interviewed someone thinking they were going to be a great fit for your organization, only to find out three days later that you made a huge mistake? I have. In fact, I have been duped hundreds of times. And every time it happens, I think: "I can't believe that happened…again!"

Actually, that is why I am writing this column–to share some pointers I have learned, the hard way, over the years. Here are my top five tips on how you can spot a bad employee during an interview.

1. If they miss their first interview, they are probably going to be a bad employee.

This one seems like an obvious one. But I cannot tell you how many times I have had people not show up for an interview and reach out to them, hoping the reason they didn't show up was because of some actual emergency that prevented them from coming in or calling. Of course, the real reason they missed the interview (I would soon learn) was because they were a bad employee.

2. If they show up for the interview wearing pajama bottoms, they are probably going to be a bad employee.

This is a good one. The way people dress for an interview, can tell you a lot about what you can expect from them. I mean, when they are too lazy to put on actual pants FOR AN INTERVIEW the joke is really on me. PS: When did pajama bottoms become outerwear?

3. If the reason they are not working is because their last manager was the problem, they are probably going to be a bad employee.

If I had a nickel every time someone told me the reason they are no longer working was because their last manager was an incompetent jerk, I would have 4,329 nickels. I would also have 4,329 new hires who turned out to be bad employees. If you listen closely, you can hear them in an interview right now telling the hiring manager the reason they no longer work for me is because I was an incompetent jerk.

4. If they show up late for the interview, they are probably going to be a bad employee.

This one is straightforward and needs the least amount of explanation. If they show up late for the interview, they will show up late for work.

5. If the only questions they ask is about pay, break times, days off, vacation time, sick time, and my favorite, "How many times can someone call out before they are fired?"

I wish I was making that last part up, or at the very least, highlighting a single incident. I'm not. I have been asked that question many times during interviews. Of course, it is a huge red flag, and I am always tempted to stop the interview right there. But I don't, because I am often short-staffed, and I am hoping (maybe) they are

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American College of Health Care Administrators names Rudy Michalek as interim CEO

Rudy Michalek, a 38-year member and a Fellow of ACHCA, was named Interim President and CEO of the organization, effective May 24, 2021. This appointment follows the announcement of the retirement of current President and CEO, Bill McGinley, CNHA, CALA, CAS, HSE, FACHCA. As part of this transition of leadership, the ACHCA Board of Directors is engaging in strategic planning for the future direction of ACHCA, including efforts to explore collaboration with other organizations to strengthen the role of ACHCA as it represents administrators and executive directors in long-term care, post-acute care, and senior living settings.


Rudy Michalek

Mr. Michalek, who has an MBA from De Paul University and is President of Premier Care Management, has served the organization as a Chapter Officer, Committee Chair, Member, and in various roles on the national Board of Directors. With over 40 years of successful operational experience in health care facilities and organizations, he will bring those skills to ACHCA management. Upon his appointment, Rudy stated, "I look forward to this opportunity to serve ACHCA and all of its membership. I will endeavor to fulfill the ACHCA's vision and mission."

Rudy takes on the position under the guidance, and building on the leadership, of Bill McGinley, ACHCA's President and CEO for the past three years. "As someone who has worked closely with Rudy for many years, I couldn't be more pleased to welcome him to the ACHCA staff," said Mr. McGinley. "Rudy's experience, demonstrated leadership, and passion for his work and the College will provide incredible support to our members and staff as they continue to advocate for excellence in post-acute care and aging services."

How bad has it been during the pandemic?

NUMBER OF DEATHS IN NEW ENGLAND SENIOR CARE FACILITIES

Through April 23, 2021

State	Deaths
CT	2,688
ME	372
MA	7,666
NH	840
RI	1,610
VT	145

Vermont had the lowest mortality rate in the country. Massachusetts lost nearly 20% of nursing home residents. Proportionately, the three northern states had the lowest percentages. On average, 64% of all fatalities from covid occurred in senior congregate care facilities.

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Employer FAQs regarding CDC's new guidance

by John L. Litchfield, Mark J. Neuberger, Daniel A. Kaplan, and John R. FitzGerald

State and local order rule and regulatory impact

Q: Does the CDC's new guidance for vaccinated people impact state and local orders or rules that may still require mask wearing and social distancing?

A: No. As noted, the CDC's guidance is just that–guidance–and the CDC does not have authority over state or local governing bodies that may impose stricter public health rules. For example, many municipalities, such as Chicago, have maintained that masks must be worn in restaurants and bars unless patrons are actively eating or drinking. Likewise, many municipalities still maintain capacity limits and masking requirements in buildings and public spaces, such as offices and manufacturing facilities. The same sort of restrictions are also applicable in many states by various Executive Orders issued by their governors – for example, Executive Order 192 in New Jersey requires businesses to require employees to wear masks in the workplace, with limited exceptions. Unless and until these state and local orders governing these issues are revised or rescinded, employers should maintain existing mask wearing and distancing policies where required by law.

Employer inquires and confidentiality requirements

Q: If I want to allow vaccinated employees to drop the mask, how can I verify vaccination status? What can I ask for?

A: The EEOC has expressly stated that employer inquiries into employee vaccination status is not a prohibited medical inquiry under the Americans with Disabilities Act. Moreover, requesting proof of an employee having received a COVID-19 vaccination, such as by providing a copy of the completed CDC-issued vaccine card or a printout of vaccination status from a health care provider that administered a vaccine, is permissible. This is because such a request, by itself, is not likely to elicit information about a disability and is thus not a prohibited disability-related inquiry. If you ask for proof of vaccination from employees, you should develop a written protocol for collecting such information and keeping it confidential except for those limited managers who have a legitimate business need to know.

Q: But, doesn't the CDC-issued vaccine card contain confidential information?

A: All that is contained on the CDC-issued vaccine card is the individual's name, birth date, the vaccine administered, and the date on which it was administered. It does not contain medical diagnoses, medical history, genetic information, or other personal identifying information that employers do not otherwise already have as to each of their employees. So, while it is a best practice to limit access to information indicating who has, and who has not, submitted proof of vaccination status, there is no confidential information contained on CDC-issued vaccine cards that employers do not otherwise have. That said, if you are requiring proof of vaccine status to implement a new mask policy in line with updated CDC masking guidance, you should warn employees (in writing) not to provide any medical information as part of their documentation to avoid implicating the ADA's prohibitions on medical inquiries.

Q: If an employee reveals they have not received a vaccine and/or do not intend to be vaccinated for COVID-19, can I ask them why?

A: Yes, but be very careful. There may be many reasons why an employee chooses not to get vaccinated. If they state a reason based upon their religious beliefs (which under the law is very broadly interpreted) or based upon a claimed disability, the employee may be entitled to a reasonable accommodation. Management's outright rejection of a claimed religious or disability basis for not getting vaccinated may lead to claims of discrimination. Thus, it is strongly recommend that only those managers who are knowledgeable about the laws on religious and disability discrimination have that detailed of a discussion with an employee.

Q: How do I maintain an employee's vaccine status as confidential if I am expected to enforce a mask policy that allows only fully vaccinated individuals to go mask-free in the workplace?

A: This is certainly a challenge that employers will face in enforcing revised masking and distancing policies in light of the CDC's new guidance for vaccinated individuals. Limiting who has access to information regarding employees' vaccination status is advisable. For example, only individuals in HR who are charged with enforcing workplace conduct or health and safety protocols should be given access to employees' vaccine status information; and, such information should only be provided for the limited purpose of enforcing the policy against violators who are not vaccinated. Inevitably, individuals who can remove masks indoors because they are vaccinated will, simply by the act of doing so, reveal their vaccine status. Those who are not vaccinated, and thus are required to continue wearing masks, may likewise reveal their status by wearing masks (though it is likely that individuals who are vaccinated and could otherwise drop their mask, will continue doing so for the time being, thus making it difficult to obviously distinguish between those who are not vaccinated and those who are but are choosing to continue mask wearing). The risk is not so much in these practical revelations of who is vaccinated, but rather in how they are treated; management and supervisors should be trained to not exclude masked individuals from meetings, projects, business travel, and other employment opportunities, because doing so may inadvertently trigger disability, religious or disparate impact liabilities.

Health and safety rule and regulatory impact

Q: Does the CDC's new guidance for vaccinated people impact OSHA (the Occupational Safety and Health Administration) and State OSHA rules and regulations?

A: No, and then again, yes–to an extent. As

Continued on next page

FAQs about going mask-free

Continued from preceding page

noted above, the CDC's new guidance is only guidance, and does not trump the federal or state health and safety rules and regulations. However, where those federal or state health and safety rules and regulations incorporate or rely upon CDC guidance – which is the case for many – the new guidance will have an impact. See more on this below. On May 17, 2021, OSHA told employers it is reviewing CDC guidance and will update its materials on the website accordingly and until those are complete, OSHA says to refer to the CDC guidance on measures appropriate to fully vaccinated workers.

Q: Are there specific OSHA rules or regulations that require mask wearing? Does the CDC's new guidance affect these rules and regulations?

A: Initially, there are NO federal health and safety rules or regulations that specifically dictate or require mask wearing – that is, there are no mask regulations; at least not yet. There are new emergency regulations proposed by OSHA that had recently passed vetting by the White House, and were expected to be released last week; however, this did not occur. Many believe that these emergency rules may now need to be re-written or scrapped entirely due to the CDC's new guidance.

However, the OSH Act does contain a "General Duty Clause," which requires employers to provide their workers with a workplace free from recognized hazards that are causing or likely to cause death or serious physical harm. OSHA has interpreted this Clause as necessitating employers to require their employees to wear masks in the workplace in order to suppress the spread of COVID-19 in the workplace. This means suppressing the spread was based on a lack of evidence reflecting the effectiveness of COVID vaccinations in suppressing spread (as opposed to enhancing safety for the vaccinated from harm). The CDC new guidelines, however, note that there is a growing body of evidence (though not yet complete) that "that fully vaccinated people are less likely to have asymptomatic infection and potentially less likely to transmit SARS-CoV-2 to others." As such, the new guidelines may affect OSHA's use of the General Duty Clause for failures employers to mandate mask wearing in the workplace.

Q: Are employers required to only comply with the federal OSHA rules and regulations?

A: No. There are 22 states and U.S. territories that have their own State OSHA programs: Alaska, Arizona, California, Hawaii, Indiana, Iowa, Kentucky, Maryland, Michigan, Minnesota, Nevada, New Mexico, North Carolina, Oregon, Puerto Rico, South Carolina, Tennessee, Utah, Vermont, Virginia, Washington, and Wyoming. Employers with operations in these states must comply with their state's OSHA rules and regulations. And, some of these states have adopted specific mask-wearing requirements.

For example, according to a NELP (National Employment Law Project) article, as of May 10, 2021, California and thirteen other states have adopted emergency state-specific health and safety orders that generally require mask wearing unless infeasible or if wearing a mask would otherwise cause its own safety hazard. Until these emergency state OSHA rules and regulations are withdrawn or amended, employers in these jurisdictions must con-

Continued on next page

The Legal Perspective: Questions and answers about CDC's new guidance

Continued from preceding page

tinue to comply with the mask-wearing requirements.

Mandatory vaccination programs–are these legal? Does CDC's new guidance change the answer?

Q: Are mandatory vaccination programs legal under federal law?

A: Yes–for the most part. Currently, no federal law would prohibit or bar an employer from implementing a mandatory vaccination program. However, there are few "exceptions" that must be respected: (i) for employees who have a disability that prevents them from being vaccinated (the Americans with Disabilities Act prohibits discrimination in this circumstance), (ii) for employees who have a sincerely held religious belief or practice wherein being vaccinated is contrary to that belief or practice (Title VII of the Civil Rights Act prohibits discrimination in this circumstance); and (iii) for employees who are represented by a Union (depending on the applicable collective bargaining agreement, the employer may need to bargain over a mandatory vaccination program before implementation). These exceptions are not automatic, as we discussed in prior Employment Law Perspective Articles (Article 1, Article 2). In addition, just because a mandatory vaccination program may be legal under federal law, does not mean it is legal under state law, and does not mean it is a "good" idea: two additional topics explored below.

Q: Are mandatory vaccinations legal under state law?

A: As is typical with answers from lawyers to straightforward questions, the answer to this question is, it depends. First, it depends on when this question is asked, as there are presently a number of states considering legislation to prohibit discrimination based on vaccination status, and would likewise prohibit employers to mandate vaccinations. Second, it depends on the type of business at issue. For example, healthcare organizations are prohibited from mandating vaccinations in the State of Oregon for healthcare workers, but the law is currently limited to that industry. Therefore, what does this mean for your business: you should NOT implement a mandatory vaccination program until you have confirmed that your state and

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- Publicity. If the publicity was extremely bad because of high levels of infection and/or deaths, or just because advocacy groups and the press decided to do hatchet jobs on skilled nursing providers, recovery will be painfully slow. Marketing tip: In marketplace areas where your operation is the only game in town, there may be no better rationale or time to do a brand refresh. The American public has a very short attention span, and the fast news cycle can be in your favor.
- Fear. How long the fear of contagion will affect consumer behavior is unclear; there has not been much good research done about this. The demand for skilled nursing is not driven by consumer choice, but rather by exigent need. There are steps that can be taken to mitigate fear in the community and among consumer prospects. And while the length of this article doesn't allow me to go into detail, the principles are: a. tell them what you're doing to protect them; b. be specific with numbers; and; c. show them images & pictures to "display" safety.
- Demographics. Remember that the 85+ age cohort was born at the very bottom of the trough in the demographic dip. In the next five years, the size of the 85+ cohort will begin to slowly increase but will need to be adjusted for lower survival rates due to the pandemic.

Value based healthcare will be devastating

None of us should forget that The Affordable Care Act was designed to both make insurance more available (which it has) and to reduce the costs of medical services in the United States (which it hasn't). One of the central tenets of cost reduction (remember "The Triple Aim?") is so-called value-based healthcare. Once the noise about the pandemic subsides there will be a renewed push for VBH, and long-term care providers will once again receive intense focus from CMS and other intermediaries. There's no moralizing involved: The variability in charges is too great, so LTC is a target. Bundles, episodes of care, risk-based population adjustments will become commonplace.

Value-based healthcare will squeeze the last crackling breath from many long-term care providers

Value-based healthcare will squeeze the last crackling breath from many long-term care providers, especially those serving the poor, indigent, and otherwise marginalized populations in marketplace areas where other providers take a seat at the table. We estimate another 380 to 1,100 SNFs will go bankrupt or close as a result of VBH. To prevent this, there would need to be an entirely new model for congregate custodial long-term care, and in the immediate guilt-shifting, post-pandemic world, there will be little appetite for novel ways to convert decrepit buildings, pay adequate wages, or fund operating losses.

Crises in employment will become entrenched

Not to put too fine a point on it, but where will the help come from?

Workforce, staffing, or labor: No matter what label you assign, the "means of production" in long-term care is people! We can be fascinated with robotic dogs & cats and pill-dispensing R2-D2s that roam hallways, but the bottom line is that efficiencies are hard to find, and it is simply not possible to provide long-term care without carers. Most frontline caregivers are women, women of color, and often those who work multiple jobs. These are what sociologists refer to as asset limited, income constrained and employed (ALICE).

These individuals were among the most devastated by the pandemic, and while economic necessity has kept many of them in these positions, how attractive will these jobs appear to be going forward? Even today, all the data shows that the jobs market is heating up.

There is a fundamental supply and demand mismatch (fewer candidates for a growing number of jobs), and the inflationary wage pressure is heating up. Just before the pandemic and even during the pandemic there were growing number of states where staffing ratios were being mandated; this is just tightening the noose on many nursing centers. We are seeing a race to the bottom in the frontline caregiver market, with nursing centers and home health agencies competing with escalating incentives and bonuses for dwindling numbers of people willing to work in these challenging jobs. From a marketing point of view, the portrayal of staffing appropriateness will become a gold standard among consumers and referring professionals alike.

These are my marketing observations for the post-pandemic environment. The US has too many nursing home and assisted living beds in most locations, and there is mal-distribution of them. The regulatory/payment system is a real mess; the inventory of nursing homes is decrepit or at least obsolete; and the shortage of labor will get worse and remain endemic. The challenge is to segment the markets and to be proactive in ways that the sector has not been in the past.

For those who love a challenge, let's get started!

Stackpole & Associates is a marketing, training and research firm with a focus on the healthcare, and seniors' housing and services markets, securing intelligent answers to clients' most important questions since 1991. Irving can be reached at istackpole@stackpoleassociates.com.

Ralph Peterson

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just asking for a friend. They aren't.

I could keep going. There are a lot more warning signs of "bad employees" than the ones I highlighted. For instance, if they insist on texting but don't actually spell out the words, they are probably going to be a bad employee. If it takes them more than one day to get back to you to set up an interview; if the person who recommended them for the job is a bad employee; if you call them at 1 p.m. to schedule the interview and you wake them up; if their mom or dad calls to set up the interview: They are probably going to be a bad employee.

As always, I hope I made you think and smile.

Ralph Peterson is a three-time best-selling author and a leading expert in management development in the long-term care industry. Ralph@ralphpeterson.com

ACHCA president and CEO retires

Continued from page 3

course of his tenure, Bill has stabilized our operations, enhanced ACHCA's visibility in the post-acute community, and set us back on a successful course. His relatability, level head, and dedication to this association will be missed tremendously. On a personal note, I've thoroughly enjoyed working with Bill, especially as we navigated our way through the past year. I wish him and his wife Sue the very best as they transition into a new season of life."

Incoming Chair Theresa Sanderson thanked Bill for his years of service to the long-term care industry, and especially to ACHCA, and offered her best wishes for a long and healthy retirement. Bill was equally lauded by District One Director Matt Lessard and New England Alliance President Bob Oriol for his contribution to the New England Region.

Bill McGinley

W. Bruce Glass, FACHCA, CNHA, CALA is licensed for both nursing homes and assisted living in several New England states. He is currently principal of BruJan Management, an independent consulting firm. He can be reached at bruceglass@rocketmail.com.

Glass receives award

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District One Director, Matt Lessard comments that "the journal educates administrators across the region and the country. It also serves to unite administrators as they read about what their colleagues are experiencing in nearby states. Additionally, it sheds light on ACHCA and serves to market this great organization. Without people like Bruce Glass who are willing to work hard in order to advance the post acute industry and administrator, we would not have ACHCA."

Glass thanked the entire team, including Assistant Editor Rick Gamache, Advertising Manager Julian Rich, and past Treasurer Mark Jacob as well as the advertisers and talented columnists:. "Without the input of these individuals, there could be no New England Administrator," he says.

Kris Mastrangelo

Continued from page 3

ing and transmitting resident assessment information at 42 CFR §483.20.

- Remains a waiver: Waiver at 42 CFR §483.20(k) related to the Pre-Admission Screening and Annual Resident Review (PASARR).
- Action: The Facility must complete and transmit MDS assessments according to current regulations.

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

Your questions answered about how to handle new CDC guidance

Continued from page 16

local municipality law does not prohibit such a program?

Q: Are mandatory vaccination programs a "good" idea?

A: It depends. As we discussed in a prior Employment Law Perspectives Article, there are many variables that should be considered before implementing a mandatory vaccination program. One of the primary considerations, however, continues to be whether an employer will be liable for adverse reactions suffered as a result from mandating a vaccination that has only received Emergency Use Authorization – which continues to be the case for all three vaccinations available in the U.S. And, every employer should always take the temperature (pun intended) of its employee population (how will such a mandate "fly") before implementing, as this can lead union organizing and other considerations.

Q: Does the CDC's new guidance affect an employer's right to implement a mandatory vaccination program?

A: No. There is nothing in the new guidance that changes or affects and employer's right to create or implement a mandatory vaccination program. However, the new guidance does seem to suggest a greater benefit now to having such a program.

The Science–Why Did the CDC Guidance Change?

Q: Why did the CDC loosen its guidance on masking and social distancing?

A: Because of mounting evidence that COVID-19 vaccines are very effective. Studies show that vaccines prevent severe COVID-19 illness and death. Studies also show that vaccines prevent vaccinated people from spreading the virus. Most recently, studies have shown that vaccines effectively protect against new variants of the virus and against both symptomatic and asymptomatic cases of the virus. Although it is possible for someone who is fully vaccinated to get infected with COVID-19, it is incredibly rare and, when it does happen, the symptoms tend to be mild. Now that vaccination rates are increasing, COVID-19 cases and deaths are declining. The CDC may alter its guidance again if new variants of the virus emerge that the vaccines do not effectively protect against, but at this time, the effectiveness of the vaccines makes masking and social distancing unnecessary for vaccinated people.

Q: What does the new CDC guidance mean for people who have not yet been vaccinated or fully vaccinated?

A: People who have not yet been vaccinated, or who have only received one dose of the Pfizer or Moderna vaccines, must still wear facemask indoors and socially distance, according to CDC guidance. The CDC guidance has only changed for people who are fully vaccinated. The new guidance is a response to the effectiveness of the vaccines, which means people who are not fully vaccinated—and are therefore not protected against COVID-19—must continue taking the same precautions.

Best Practices for Masking Policies

Q: Should I create one mask policy for all employees?

A: Not necessarily. A mask policy should be catered to a particular workspace. Many employers have multiple different types of workspaces—for instance, an employer may have some employees who work in an office setting, some employees who work in a factory setting, and some employees who work in an agricultural setting. When creating a masking policy, employers should consider each unique workspace separately, and should decide who can take their masks off, when they can take their masks of, and where they can take their masks off.

Q: If I do not feel comfortable lifting the mask mandate at my workplace now, when is the safest time to do so?

A: Nothing in the new CDC guidance prohibits an employer from keeping a place a mandatory masks in the workplace requirement. An abundantly cautious approach to masking would be to require masks until the CDC announces national herd immunity. Under this approach, an employer would require its employees to wear facemasks until the CDC announces that everyone in the country—vaccinated or not—can begin taking their masks off indoors.

Q: What should I do to prevent conflict in the workplace related to mask wearing?

A: Employers should expect some employees to have strong opinions about mask wearing. Employers can take steps to prevent conflict. First, employers should communicate to their workforce that employees are not allowed to confront one another about mask wearing. In other words, whatever opinion an employee has about his coworkers' mask wearing habits, he should not take matters into his own hands The employer should have a clear policy in place about how an employee can report mask wearing issues and it should not involve employee-to-employee communication. Second, employers should implement a policy that bans employees from asking one another about their vaccination statutes. The policy should clearly state that an employee who does ask a coworker about their vaccination status will be disciplined.

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