New England
ADMINISTRATOR

September
2021

"Clothes make the man. Naked people have little or no influence in society."
-Mark Twain

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Are We There Yet?

(Hopefully) emerging from COVID

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THE C.A.R.E. EXPERT

Top 15 things to know about vaccinating staff

by Kris Mastrangelo, OTR/L, MBA, LNHA

COVID-19 HAS CERTAINLY TAKEN ITS TOLL ON THE NURSING HOME INDUSTRY WHERE STAFFING WAS A CHALLENGE EVEN PRIOR TO THE COVID-19 PANDEMIC.

The recent directive by the federal government that is mandating that all employees of skilled nursing facilities to be COVID-19 vaccinated on or about October 18, 2021 (the estimated last day for final vaccine shot on October 4, 2021) further compounds the staffing crisis and could result in significant negative ramifications to the clinical, financial, and operational performance of nursing facilities.

This new federal mandate comes shortly after the May 11, 2021 regulation requiring nursing homes to report the status of completed COVID-19 vaccinations weekly for both residents and staff to the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN).

According to a CMS press release, "The new vaccination reporting requirement will not only assist in monitoring uptake amongst residents and staff but will also aid in identifying facilities that may need additional resources and/or assistance to respond to the COVID-19 pandemic." Another CMS press release indicated, "On August 18, 2021, the administration said nursing homes must vaccinate their staff against COVID-19 if they want to continue receiving federal funding."

Kris Mastrangelo

On August 20th, 2021, Mark Parkinson, the president and CEO of the American Health Care Association and National Center for Assisted Living (AHCA/NCAL), made the following statement regarding the Federal requirement that nursing home staff must be vaccinated against COVID-19 in a forthcoming regulation:

"We appreciate the administration's efforts to increase COVID-19 vaccinations in long term care. Unfortunately, this action does not go far enough. The government should not single out one provider group for mandatory vaccinations. Vaccination mandates for health care personnel should be applied to all health care settings. Without this, nursing homes face a disastrous workforce challenge.

"Focusing only on nursing homes will cause COVID-19 vaccine-hesitant workers to flee to other health care providers and leave many centers without adequate staff to care for residents. It will make an already difficult workforce shortage even worse. The net effect of this action will be the opposite of its intent and will affect the ability to provide quality care to our residents. We look forward to working with the administration in the coming days to develop solutions to overcome this challenge."

Advocates and lobbyists across the United States are requesting that states implement regulations that do not exclusively direct the COVID-19 vaccine mandate for staff solely at nursing homes, but instead, apply a regulation that covers all health care workers regardless of the healthcare setting. States that have already adopted this global concept include Maine, Maryland, New York, California, and Rhode Island. (Reminder: If a state regulation is different from a federal regulation, apply the more stringent regulation.)

Currently, approximately 62% of workers in the nursing home industry are vaccinated. The fear of a greater staffing crisis is real. In order to help skilled nursing operators effectively implement the mandated COVID-19 vaccination requirements, this article provides the top 15 things providers need to know about COVID-19 vaccination of persons entering the nursing home.

1. Develop a policy and communicate immediately

Be sure to effectively communicate the facility/company policy and process to residents, employees, contractors, volunteers, and other health care providers.

2. Know the rules

First and foremost, understand who needs to be vaccinated. To simplify, everyone that enters the facility (except for visitors) require a vaccination.

This applies to all onsite

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Home alone: Aging, housing, and care

by Irving L. Stackpole, RRT, MEd

AN EMERGING TREND IN THE LONG-TERM CARE NARRATIVE IS THE RENEWED EMPHASIS ON HOME AND COMMUNITY-BASED SERVICES (HCBS).

Social determinants of health and non-clinical measures are emerging as key performance indicators (KPIs) among the elderly with chronic conditions. A recent Google search for "home and community-based services" generated about 4,070,000,000 results, whereas "nursing home" generated about 103,000,000 results; 39 times more for HCBS than for nursing homes. At this time, because nursing homes have been seen as the breeding ground for COVID-19, there are widespread calls for more HCBS and less nursing homes.

Those of us in the long-term care sector, whether we represent home and community-based or congregate care providers (or both), need to counterbalance popular narrative with facts, data, and good professional judgment. We also need to look around the corner and anticipate the transition and implications from the service economy to the care economy.

Irving L. Stackpole

Nursing Homes Are Essential

Despite pleas from various "advocacy" groups and special interests to the contrary, the need for congregate, long-term, medically, and behaviorally focused care endures.

It is true that demand for, and utilization of SNFs have been declining. Utilization decreased still further as a result of the pandemic shock, but there is an underlying base of disease burden which cannot be served given the available domestic housing infrastructure, family fragmentation, and limited supply of paid and non-paid caregivers.

The US will need most of the existing SNF beds (15,269) for dementia-related care through 2050. General estimates suggest that as much as two-thirds of current SNF utilization is due to dementia-related demand. Potential new treatments for Alzheimer's and related dementias could have a substantial impact on future demand.

Nursing homes are not going away, but they do need to change. While we all recognize that drastic changes are desperately needed in the built environments, program environments, and staffing, these factors will dictate and determine how the demand is fulfilled. The need for congregate, long-term care centers staffed with trained professional nurses and caregivers will not disappear.

Assisted Living Will Be Democratized

To date, the assisted living sector has selectively targeted high-income population segments and has resisted medicalization. Both will change.

Democratization of assisted living will occur. The availability, affordability, and accessibility challenge for the assisted living category was described very well in a recent Health Affairs article. [i] As "old and alone" becomes more endemic, society (and the long term care sector) should/will advocate for financial supplements and support to enable more of the aged population to relocate to assisted living. Currently penetration of the age-qualified markets is ~11% nationwide. Even if this increases to 20% (which the existing supply of assisted living residences would easily absorb) 80% of the age-qualified population would be residents in other locations: for example, about 2.5% in SNFs, 2.5% in CCRCs, 2.5% in Board & Care, and 72.5% in their own homes. Some of these "homes" will be apartments and town homes in age-restricted housing, or so-called "active-adult" residences. This brings us to loneliness as the new epidemic.

The medicalization of assisted living is occurring before our very eyes, as more and more middle-income residents access care through Medicare Part C (Medicare Advantage). While representative provider groups and membership organizations might

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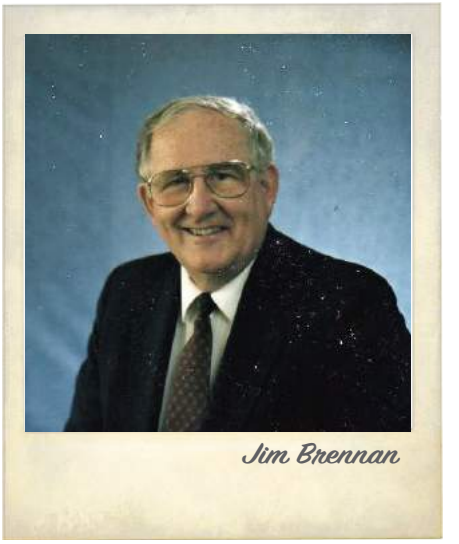
The blue-eyed hawk

by Edison Beaumont



Jim Brennan

To those who've been around long enough to remember Jim Brennan, just saying his name brings a smile to our faces. Jim is 88 years old now and living in East Longmeadow MA. I had a chance to connect with him recently and he shared some of his favorite memories from a long and meaningful career in long term care. When I asked him to give me some background information for this article, he began with, "I was born at a very young age." Then he smiled and I saw that twinkle in his blue eyes.

Ladies and gentlemen, Jim Brennan has not changed.

During his storied career in and around nursing homes, Jim created some incredible activity programs, such as the "Ho Ho Hotline," a nationally known program that became a staple during his years as the National Community Relations Director for the Hillhaven corporation. This oft-imitated idea featured nursing home residents fielding phone calls from children wishing to speak with Santa, (sometimes they got to talk with Mrs. Claus), and the residents were just as thrilled as the children when they interacted.

St. Joseph's The Hawk still soars today.

Another well-known and highly successful program that Jim conceptualized and carried out was the "Rock and Roll Jamboree," featuring residents in rockers and wheelchairs, and sponsors who pledged money for the amount of time residents rocked or rolled. The events raised $20 million in total for the American Heart Association, which is astounding because sponsors paid just one penny per minute of resident activity.

With the Hillhaven corporation, Jim Brennan became a widely sought-after public speaker, and he spoke across the US as well as in South America, Europe, and Asia, where he helped recruit Philippine nurses decades ago. His talks often focused on positive thinking and were constructed primarily for audiences of activity directors and administrators.

Mr. Brennan had a predilection for public speaking. He seems to have been born that way. Jim was raised in Sayre, PA, a small town located just south of the NY-PA border, about 20 miles from Elmira. Although small, Sayre, with a population of 5,000, has produced two major league baseball players.

Sports were a way of life in Sayre. Jim's father, Jake, was a three-sport standout in Sayre High School, excelling in football, basketball, and baseball. He was so good he was chosen as the top athlete of the century for the school, even though he never graduated. Like so many others during the Depression, Jake Brennan dropped out to earn what he could to help his cash-strapped family. Later, he became a basketball and baseball coach for men, women, and children in the local community. It was from watching and listening to his father that Jim learned how to teach and how to inspire.

Jim's mother, Coral, was the disciplinarian of the house, often asking him, "Why did you do that? Was it the right thing to do?" Jim later incorporated parts of her approach into his practice as an administrator, and later, his books and lectures.

Despite his father's love of athletics, Jim was never drawn to organized sports. He was a cheerleader at his college, St. Joseph's in Philadelphia.

According to Jim, his greatest accomplishment occurred during this time. Since the school teams were named the Hawks, Jim advocated for getting a real live hawk as a mascot. When he was turned down, Jim's creativity took over. He purchased a life-sized hawk costume with $120 of his own money, without the school's knowledge or permission, and on January 4, 1956, showed up at a basketball game against La Salle University, to lead the cheers as the team's mascot. (St. Joseph's won the game.)

The hawk was a hit, as was Jim, who now had a new persona to perform as in front of crowds and bring joy to fans. Today, the college's mascot is still the hawk, but the costume costs $10,000. The NCAA once named the school's hawk as the top mascot in the US.

After college and a stint in the marines, Jim became an insurance salesman until one day his client talked about a purchasing a nursing home near Springfield, MA. The client invited Jim to tour the home, and then offered Jim the position of administrator despite his lack of experience. The year was 1969, and licensure was still a few years away.

On his first day on the job, Jim read in a policy manual that the autoclave needed to be in good working order. Not knowing what an autoclave was, Jim asked the Director of Nursing, "Is the autoclave in good working order?" She took him to see it, and that's how he learned about autoclaves. Much of his education occurred this way, on the job, as Jim asked many questions and listened intently to the answers.

It was at his first nursing home job that Jim adopted a credo that hung on the wall: "We respect the dignity of each individual." He took it to heart and used this perspective to hone his approach as an administrator.

During a 10-year stint as administrator, Jim learned how important it was to praise someone, and how many ways there are to do it. (There are four. It's in his book.) He also created 9 different way to discipline someone. He used discipline to help his

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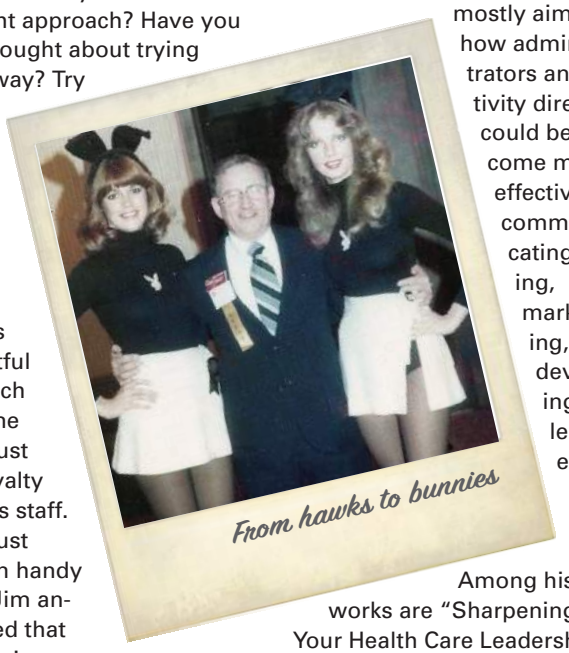
staff grow, not as a punitive approach. He added to the questions his mother used to ask him by saying, "I noticed you did X. Do you think that is the right approach? Have you ever thought about trying it this way? Try that and let me know how it works out."


From hawks to bunnies

Jim's respectful approach and tone built trust and loyalty with his staff. That trust came in handy when Jim announced that the nursing home would be dropping out of the state Medicaid program, and focusing on serving the private-pay market only. He was tired of the shortcomings of the Medicaid system and the regulatory burdens it placed on his staff.

Jim had established solid working relationships with the local hospital social workers and with the editor of the town newspaper. He was confident he could fill his beds and control the narrative in the press if necessary. It wasn't. Jim Brennan reached 100% private pay census within a short time.

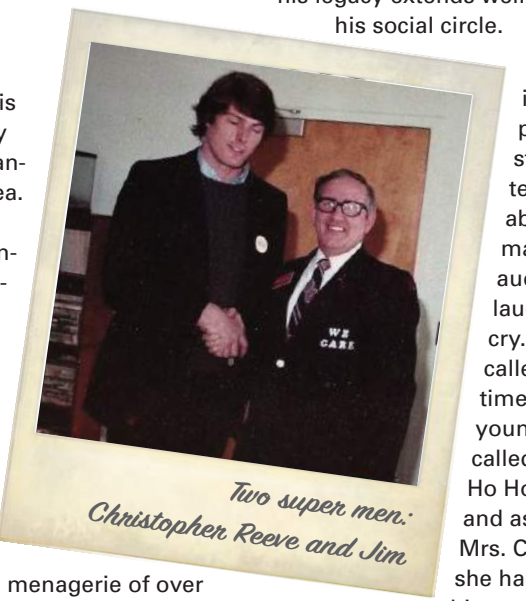
It was around this time that he accepted the national position with Hillhaven, and public speaking became a way of life. His work around the country on behalf of nursing home residents allowed him to rub elbows with celebrities and political leaders, from Barbara Bush to Anson Williams (Happy Days), actress Kristi McNichol, Cesar Romero (Joker on Batman TV series), and others. His photograph collection features Jim with First Ladies, Playboy Bunnies, and Miss America.

Along the way, Jim found the time to author ten books, mostly aimed at how administrators and activity directors could become more effective at communicating, hiring, marketing, and developing as leaders.

Among his works are "Sharpening Your Health Care Leadership Skills," which including learning to be more compassionate. While most education in long-term care focuses on tasks and regulations, Jim Brennan recognized the importance of developing a leader's people skills back in the 1970s.

As Jim traveled the country, visiting nursing homes and conducting training workshops, he met many residents who left their mark on him. He recalls a resident who was a fighter pilot in World war I and was shot down twice by a famous red plane being piloted by Baron von Richthofen, better known as the Red Baron. Jim also met a gentleman in a Memphis nursing home who had once taught a young man to drive a truck. The young man was Elvis Presley.

Often, residents talked to Jim about missing their family pets. Jim couldn't help but think of how people reacted to the hawk costume he wore at college sporting events. Again, his creativity birthed another idea. Jim started incorporating puppets into his training lectures. At one point he owned a menagerie of over 100 animal puppets, many of which made appearances during his presentations. Activity directors all over the country began incorporating puppets into their programs.



Two super men: Christopher Reeve and Jim

During all his travels and speaking engagements, Jim visited 49 of the 50 US states. He never made it to Alaska, simply because the distance between nursing homes was so great that there were not enough people in any one area to hold a training program.

The ACHCA recognized Jim's accomplishments in 1990 with its Public Service Award. He remains in touch with several professionals in our field, but his legacy extends well beyond his social circle.

Jim is a peerless storyteller, able to make an audience laugh or cry. He recalled one time when a young boy called the Ho Ho Hotline and asked Mrs. Claus if she had seen his mother up in the clouds. She had passed away a year earlier. The resident was thrown off momentarily, but then quickly replied, "That was your mother? Yes, I have seen her, and she watches over you and she loves you."

Jim's blue eyes light up when he is asked about his many grandchildren and his five daughters. His pride and love are palpable. He says that in his youth he was filled with hope, and through the long sweep of his life his experiences have given him rich memories that are more precious than all the hope he ever had as a child.

Jim has even had a premonition about how he would eventually die. "I will be shot by a jealous husband," he said with a wry smile and a twinkle in his eye.

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For more details: thenealliance.org

The nurse administrator and aging

by Sheldon Ornstein Ed.D, RN, LNHA

Careers in long term care presents a challenge to the field of geriatric nursing. The literature is replete with articles addressing this issue. An absence of long term care nursing as a specialty is clearly evident, according to recent statistics. Nevertheless, nurses continue leading the way and having an impact in all specialties of patient care.

The nurse, in long term care, however, must be knowledgeable with issues that deal with legislation that can affect the care being rendered. Long term care is a field for the adventurous and dynamic nurse.

Just as Florence Nightingale held her ground during her assignment in the Crimean War, nurses today who have the conviction will, inevitably, make those changes that are needed to influence the growing value of geriatric nursing practice.

There are, in fact, nurses who have turned to positions requiring greater authority. One example is administration. As such, administration calls for considerable responsibility and potential for making important contributions in the field of long term care. The question is, however, what are the requirements for achieving and carrying out a successful administrative role? The researchers, McClosky and Grace, recommend, "The administrator must have knowledge about human relations, political and managerial skills, decision making, and budget management." This also includes intuition, sensitivity and a willingness to allow others to test their ideas while risking possible failure.

An organization that thrives best is one in which ideas are generated at all levels and in which employees can also be involved at implementing change.

At present there is a realistic shortage of qualified geriatric trained nurses with all of the previous mentioned skills. Most employment agencies are constantly seeking individuals for the position with an MBA. Long term care administration can be a fertile field for the qualified nurse.

Several decades ago nurses managed nursing homes until Medicare regulations, reimbursement issues, state mandated policies, and specific care practices defined the nature of the nursing facility with the emergence of the director of nursing, a fairly recent role. The question now is what does the role require? An assertive individual must be eager to gain and ultimately exercise power, and ready to cope with the demands of multiple regulatory policies and agencies along with profit-oriented issues.

With that shift from a clinical staff position to director of nursing, responsibilities now fall squarely on her shoulders to oversee that patient care is being rendered at all facility levels. She needs to be tactful, patient, empathetic, and have a broad range of skills that go beyond the basics that were once practiced at the patient's bedside.

For example, she might be called at night to deal with a faltering heating system and a wintry temperature that is dropping, or help find a patient who has wandered away and could be in serious trouble. In effect, she could be involved in an endless number of complex activities and issues that might tax her ability to continue in the position, and for anyone else who would be in similar circumstances.

In most situations that deal with the quality of patient care being rendered, we observe a direct correlation to the DNS competence and commitment to the facility's functioning and the health and safety of the patient population.

The following suggestions deal with the potential success of the nurse administrator:

- Surround yourself with competent and loyal individuals who will complement your leadership skills and talent as a leader.
- Prepare your thoughts well in anticipation of questions that staff and relatives want to ask.
- Be fully acquainted with background and data pertaining to daily tasks and/or projects that will require additional preparation.
- Develop collegial relationships with staff, heads of other departments, on site professionals, assigned consultants to Nursing, who can aid you with productive ideas and complex problems that may at first appear unsolvable.
- Become involved in the larger picture such as outside participation in networking via professional organizations, informal group presentations, seminars, or just plain get-togethers for brainstorming sessions.
- Have your previous survey reports re-reviewed for earlier violations that were incurred. Seek to

Continued on page 16

The compliance and ethics program and COVID-19

by David Barmak, JD

Federal and state financial support have enabled skilled nursing facilities (SNF) to remain financially viable while continuing to provide care during the devastating Coronavirus outbreak.

In addition to grants and loans, many regulatory requirements have been waived to enable SNFs to meet the needs of their resident populations. An effective compliance and ethics program is more important than ever to address new risk exposures arising out of the continuing COVID-19 pandemic.

The Coronavirus Aid, Relief, and Economic Security Act (CARES Act) provided much needed funding to SNFs. The compliance risks are enormous as part of the terms and conditions of the loans. The compliance and ethics program should assist in keeping track of the funding provided and understanding the requirements regarding potential repayment obligations.

The Department of Health and Human Services has issued numerous individual and state waivers to temporarily modify or suspend certain Medicare and Health Insurance Portability and Accountability Act (HIPAA), among others, requirements. The compliance and ethics program needs to monitor waivers as they are extinguished and ensure previous processes are restored and adjusted. Such waivers address diverse areas including, but not limited to, telehealth and telemedicine services, Medicare Conditions of Participation, Physician Self-Referral and Anti-Kickback Statute requirements, HIPAA privacy and security requirements, COVID-19 related billing and reimbursement, and increased government oversight and enforcement.*

The federal government agencies are focusing on SNFs to ensure COVID-19 relief funds were utilized in accordance with all terms and conditions.

The federal government agencies are focusing on SNFs to ensure COVID-19 relief funds were utilized in accordance with all terms and conditions. For example, money has been allocated to the Department of Health and Human Services' (DHHS) Office of Inspector General (OIG) for fraud, waste, and abuse enforcement. The OIG's recent strategic plan includes oversight of COVID-19 funding appropriated to DHHS.

The above COVID-19 risk areas can be managed through an effective compliance and ethics program. The seven elements of an effective program can address these risks as follows:

Standards, policies, and procedures: Changes in legal requirements necessitate modification and/or new compliance policies and procedures. COVID-19 risk areas must be reflected in order to keep the compliance and ethics program current and relevant.

Administration and oversight: The compliance and ethics officer should take the lead on applying the compliance and ethics elements to the COVID-19 risks. It is critical that the governing body of the SNF be kept abreast of both the risks and the measures implemented in order to adequately address the risks from a compliance perspective. The compliance and ethics committee should direct auditing and monitoring efforts, as well as the compliance and ethics officer's activities, in addressing COVID-19 risks.

Effective lines of communication: Internal reporting mechanisms and anonymous hotlines without retaliation become even more important during times of increased federal funding because of potential whistleblowers. The realization of potential violations, as always, is a serious issue for which management must remain vigilant.

Education and training: Timely and effective training and education programs must be relied upon to communicate changing requirements and expectations for staff compliance.

Risk assessment, monitoring, and auditing: COVID-19 risks need to be ascertained, with actions prioritized in response to these efforts. The compliance and ethics work plan needs to be adjusted accordingly. Monitoring and auditing activities are needed to mitigate the SNF's risks. Areas to focus on include waivers, relief funding terms and conditions, and billing requirements.

David Barmak

Investigations and corrective action: Investigations of suspected non-compliance related to COVID-19 requirements must be conducted in a timely fashion, with findings and analysis thoroughly documented, followed by necessary remedial actions.

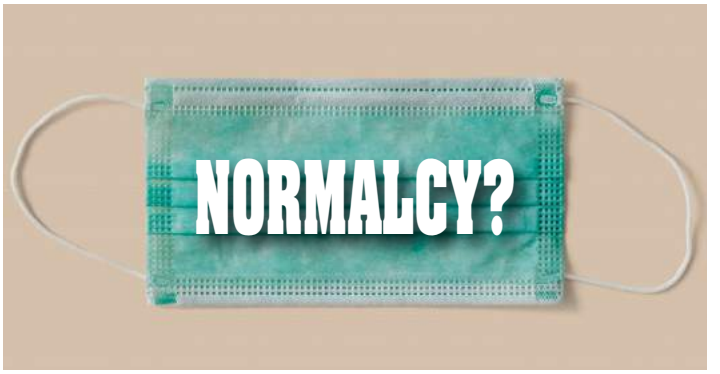
Discipline for noncompliance, and screening and evaluation of employees, physicians, vendors, and other agents: Compliance and ethics officers must be sure to emphasize the importance of applying this element of an effective compliance and ethics program to COVID-19 requirements. The expectation that all individuals will be screened against the Office of Inspector General's (OIG) List of Excluded Individuals and Entities as well as state requirements before hire and throughout employment to ensure they are not sanctioned has not changed as a result of COVID-19.

An effective compliance and ethics program should be able to incorporate the various risks associated with COVID-19. Compliance and ethics committees and officers must direct their attention, in addition to the myriad of risks currently addressed with respect to fraud, waste, and abuse and privacy and data security, to include a focus on COVID-19 risks.

*Reference: Urbanowicz, Peter, et al (July 2020). The Seven Elements of Effective Compliance Programs to Manage Your Organization's COVID Risks. Retrieved from: https://www.alvarezandmarsal.com/insights/seven-elements-effective-compliance-programs-manage-your-organizations-covid-19-risks

David Barmak is CEO of Med-Net Concepts. He has provided legal and compliance services to members of the healthcare industry for almost 30 years. Since 1997, Barmak has been representing skilled nursing facilities, medical equipment suppliers and other healthcare providers with matters related to healthcare law and business law. He received a JD from Cornell University and a BA from Duke University. Barmak has lectured and written on issues affecting healthcare providers and organizations including corporate compliance programs, antitrust concerns, integrated delivery systems and managed care contracting. Barmak's legal expertise is in the areas of corporate compliance, risk management, and operational legal affairs.

by Bruce Glass, FACHCA



We survived (barely) the first two waves of COVID, and now we can go back to "normal." Or not.

The Delta variant is sweeping through the country–and congregate living is not being spared. A recent Boston Globe headline noted that cases are rising rapidly in Massachusetts nursing homes. How can that be? Haven't all residents been vaccinated?

Indeed they were. But staff were allowed to decide whether they would get the needle.

The result? Across New England the appalling rate among staff is less than 70%. The rates are similar among hospitals and home care. And, since over 98% of cases are among the non-vaccinated, those anti-vaxxers have brought COVID back into facilities.

Why are healthcare professionals more reluctant to receive the vaccine than the general public? It is beyond my comprehension. In California and other states, some nurses have formed anti-vaccine organizations, spreading false information. This gives a veneer of respectability to a completely irrational position. In contrast, 96% of physicians around the country HAVE been vaccinated.

As a Libertarian, I am a strong believer in government involvement only when it is essential. But when public health is at risk, individual liberty must yield. Personal preference does not include the right to infect others.

What about exemptions? Most states recognize exemptions for religious or medical reasons. The problem is that there are really no religions that object to vaccines, except possibly Christian Scientists. In reviewing the literature, there are also almost no medical reasons to refuse the vaccine. What most often occurs is that deniers game the system. There are numerous online directions explaining how to claim an exemption.

Governors should have mandated vaccines for health care workers months ago. They are just now beginning to do so in several states. Without a doubt such a mandate is necessary. As desperate as we all are for staff, we cannot allow the risk that those individuals will spread this deadly plague to those for whom they care. Healthcare professionals should be leading the way, not fighting it. Individual facilities should also implement a mandate.

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.

ACHCA announces Bob Lane, CNHA, FACHCA as new president and CEO

Bob Lane

The American College of Health Care Administrators (ACHCA), the only association dedicated to professional development and advocacy for the nation's post-acute and aging services leaders, has selected Robert (Bob) Lane, CNHA, FACHCA as its new President and CEO, effective September 7, 2021. A veteran in the health care arena, Mr. Lane has been working in health care since 1982, and in the profession of long-term care administration since 1987. He began his career in Missouri with National Healthcare Corporation (NHC), where he remained until relocating to his home state of Oklahoma in 2000. Since then, Bob has worked in the skilled nursing, assisted living and long-term acute care space, in addition to leading project teams during the seventh and eighth scopes of work for the Oklahoma quality improvement organization (QIO). Most recently, he has provided operations consulting for health care providers across the country with BKD CPAs and Advisors.

Bob holds an MA from the University of Oklahoma with a concentration in health and human services administration, and a Graduate certificate in Gerontology, also from OU. He is a Fellow of the American College of Health Care Administrators (FACHCA). He is also a Certified Nursing Home Administrator (CNHA).

Bob is the past Board Chair of ACHCA and was a member of the board since 2013. Previously, he has served ACHCA as District 5 Director and as the Oklahoma and Missouri chapter President.

Lane has served on the Oklahoma Alliance on Aging board, and as faculty for the health administration program at St. Joseph's College -Maine and the Administrator University of the Oklahoma State Board of Examiners for Long Term Care Administrators. He serves locally as Board President for Upward Transitions, a United Way agency.

Bob resides in Edmond, Oklahoma, with his wife Rose.

ACHCA recognizes Hall of Fame inductees during Convocation 2022

The American College of Health Care Administrators (ACHCA) is pleased to announce that Rev. Daniel W. Farley, Fellow Emeritus, Retired Emeritus Certified; Mark J. Finkelstein, CNHA, Fellow Emeritus; Larry I. Slatky, CNHA, FACHCA; and James L. Farley CNHA, FACHCA will be inducted into the ACHCA Hall of Fame at the ACHCA Annual Convocation. The inaugural Hall of Fame inductees will be recognized during the awards dinner on Wednesday, March 23, 2022. The ACHCA Annual Convocation & Exposition will be held March 21 - 24, in New Orleans, Louisiana, at the Hilton New Orleans Riverside.

Additionally, posthumous recognition for the Hall of Fame will be acknowledged for the founding members of ACHCA, Theodore E. Hawkins, Alton E. Barlow, Rev. Carl A. Becker, and Kenneth R. Nelson, Jr. in recognition of their leadership and vision for a professional community that supports the Administrator.

The ACHCA Hall of Fame recognizes individuals that have made significant contributions to the organization over an extended period, or for a unique and lasting contribution to the College. To be eligible for membership in the ACHCA Hall of Fame, individuals must have been a member of ACHCA for at least 15 years and attained Fellow status. Additionally, nominated candidates must have served the organization in leadership roles and contributed to its success in various ways.

"I thank the Hall of Fame Committee for their efforts in selecting our inaugural class. While circumstances changed the timing of the recognition of these inductees, it doesn't detract from the level of excellence exhibited by these individuals, nor their significant contributions to our profession. It's an honor to induct them into the Hall of Fall at our Convocation in New Orleans," states Robert W. Lane, MA, CNHA, FACHCA, ACHCA President & CEO.

Each year, the Hall of Fame Committee can vote on no more than four candidates for submission to the Hall of Fame. ACHCA National will feature the Hall of Fame recipients on the website. Hall of Fame recipients will be able to view their names each year during Convocation on a special plaque of recognition.

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Existential challenges faced by LONG-TERM CARE

by KR Kaffenberger

TODAY, skilled nursing facilities and assisted living residences face existential challenges. In the June 2020 edition of the "New England Administrator," Bruce Glass highlighted the closing of almost 60 New England facilities and noted occupancy rates after the closings only in the mid 80% range. Irving Stackpole highlighted the futility of marketing what people don't want.

In the December 2020 issue, Stackpole also highlighted low occupancy, gratuitous blaming by public officials, and blaming by the media as serious problems. He said we need to update our residential facilities, improve our labor dynamic, make useful program changes, adopt technology, and update things like the minimum data set with tools and instruments that go beyond minimum to help us improve.

In January of this year, the LTSS Center @UMass Boston published a report, "The Case for Funding: What is Happening to Pennsylvania's Nursing Homes," that examined the funding dynamics of Pennsylvania nursing homes. The lead researchers were Edward A. Miller Ph.D. and Marc Cohen Ph.D.

Their principle conclusions will not surprise administrators in the New England States:

- There will be an increased demand for care beds over the coming decade.
- Clinical characteristics of residents have changed. Residents are presenting with greater levels of cognitive impairment, psychiatric disorders, and incontinence, necessitating greater attention.
- Nursing home residents are a little poorer than they had been.
- Staff hours are largely unchanged despite somewhat greater resident need.
- Labor compensation is flat.
- Some quality metrics are better, but most are not, and deficiency scores have risen. Given the need to care for sicker people with no more staff, this result is not surprising. The authors call for increased investment in care through altered payment structures.
- Median length of stay has declined.
- Medicaid pays for more days of care and Medicare for fewer.
- Medicaid rates measured against Medicare or private pay rates are declining.
- The authors of the report conclude that "… unless there is an increase in reimbursement rates or a change in the way nursing homes are financed they will not be able to meet the needs of Pennsylvania's most vulnerable."

This report is worth reading for anyone interested in the situations faced by nursing homes today or seeking information about what is needed for the future. The information gathered, and conclusions reached, could easily apply to facilities in many New England states.

One of those interested and thinking about the future is Larry Gumina. He is president and CEO of Ohio Living, which employs about 3,500 people caring for about 75,000 adults throughout the state. It provides nursing, assisted living, home health, hospice, and other community services. Its backbone is formed by a dozen senior residential communities.

Gumina has had a broad introduction to health services. He has provided leadership in a variety of settings including hospital, assisted living, skilled nursing facility, home health, and adult day care. He has a well-rounded background with which to approach the work.

In an interview, he said the value proposition needs to change. He feels that the value proposition will be different in the future than it has been for the past several decades. He sees both occupancy and payment challenges. In this he agrees with Glass, Stackpole, Miller, Cohen, and almost anyone else who takes the future of residential elder services and elder health services seriously.

Ohio Living is planning changes in its care models and payment modalities. However, because these are other ongoing initiatives that involve other entities, there are few concrete examples of change to date. It is worth noting that Ohio Living could geographically reach 86% of Ohio elders with pharmacy services and other interventions. This suggests possible avenues for new opportunities to succeed by adding additional support services to current offerings.

Capital spending will need to be increased and care will need to move from episodic care to ongoing care that follows individuals from early aging through the lifespan. To accomplish this, organizations will need to cooperate in service provision, risk sharing, and income streams. One is reminded of the accountable care organization (ACO) model, which seemed to be keyed to hospitals and large medical practices. What if residential care providers, home health organizations and pharmacy organizations used a similar approach including relations with hospitals and doctors?

Broad customer education is also needed to assure that system transformation can occur. Investments in preventive services would need to be made and monetized. Integration of individuals into an ongoing services model would have to be sold. All of this would need to be accomplished within the structure of continuing public regulation of health services.

Gumina and Ohio Living may be uniquely positioned to move forward because of its size and presence through much of the state. In addition, the organization is nonprofit and benefits from philanthropy. Gumina acknowledges that "the foundation (Ohio Living Foundation) is very important to us."

As Barry Berman intimated when talking about the development of the first Green House model facility in New England, "…it's easy when someone supplies the money." Developing the Leonard Florence Center was not easy and was a great achievement. But without the money, as Barry pointed out, it would have been harder.


KR Kaffenberger

What does all this mean if you are not running a giant organization and don't have a huge philanthropic machine at your disposal? These ideas provide one path out

Continued on last page

TALKING DIRTY
with Ralph Peterson

Lessons from cleaning in the midst of a pandemic

"The cleaning part is going to be easy," I said when it was my turn to talk. It was Sunday morning, March 15th, 2020. The President had, the day before, declared a national emergency and shut down all non-essential businesses in the country.

For those of us in long-term care, the directive was the opposite. The owner of the nursing home I worked in called me personally at 9:30pm that night to tell me to report to a mandatory meeting the next day. I got there to find everyone had been called.

The night before, I did my best to find out everything I could about the coronavirus. Although we didn't have a lot of information at the time, I felt like I knew enough to come up with a plan.

"You've got to be joking," the director of nursing said. She looked like she hadn't slept in days, greying hair escaped from a loose ponytail in whisps around her forehead.

I shrugged and I told them what I knew. Specifically, that the virus seemed to be airborne, and maybe even passed around through hand contact, like the flu. However, the good news, as far as I saw it, was the fact that the CDC also said it wasn't a live virus.

"Why is that good news?" the administrator asked.

"It's good news in the sense that we don't have to worry about the virus "living" on surfaces," I said. "Like we do with C-diff, MRSA or VRE."

"That is not exactly what they said," the nursing director said, dismissing my claim for nonsense. I shrugged again and leaned back in my chair, trying my best to look non-defensive. It wasn't easy.

Maybe it is just me and my relationship with nursing, but it's never been good. Nursing always thinks housekeeping should be doing more, and housekeeping never thinks nursing does enough. It is probably nothing more than an organizational version of sibling rivalry, but it's real.

I stayed quiet as everyone began to talk to the person beside them, until no one could hear anyone.

"What is your plan," the administrator finally said loud enough to get everyone's attention.

"Personally, I would treat it like the flu," I said sitting up so I could explain myself further. The nursing director stole the spotlight before I could. She stood up suddenly, throwing a rolled-up piece of paper on the floor and said, "I can't. I can't." Then she stormed out of the room, overwhelmed with emotion and stress. I sat back in my chair and took in some air.

The administrator got up and did his best to calm everyone's nerves as he went after her. The owner pulled me aside and asked me what I meant. I explained how we changed our job routines during the flu season to make sure we were disinfecting high traffic touch points a few times a day. He nodded in agreement, then said, "Say it like that, the next time you talk to the group." I nodded and shrugged apologetically.

Three weeks later, the first COVID-related death of a nursing home patient was announced, and everything went to hell. Competing news stories ran 24 hours a day. Rumors started to spread like wildfire. Employees, afraid of getting sick themselves, walked off the job without notice, and the CDC and the DOH started a furious ebb and flow of making rules and then taking them back.

No one knew what to do, or who to believe. We were all afraid.

Over the next twelve months I would get the education of a lifetime. I learned how to be more collaborative. I learned it was sometimes better to try someone's idea fully, rather than to dismiss it out of hand. I worked hard to earn trust and build teamwork. I involved everyone in the decision-making process. I challenged rumors, while at the same time, learned the value of ignoring the classic signs of passive aggressive behavior: the eye rolls, deep sighs, and visible attitudes.

Most of all, I learned the people whom you could always rely on before the pandemic would be the same people you could rely on during the pandemic. And, I learned, we don't pay them enough.

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

The Marketing Guru

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overtly protest, assisted living residences of today and tomorrow look like the private duty nursing homes of yesterday. Wheelchairs, oxygen, and other assistive devices will be commonplace.

Old & Alone

Most of the elderly want to and will stay where they are. Opportunities abound to connect them to what they need and connect with them in an ecosystem of supports that can be branded, as well as act as the primary sales funnel for the future survival of the sector. Social determinants of health (SDoH) should be the new key performance indicators (KPIs) for the long term care sector. An example is the Linn Health Navigator we recently developed with a client in Rhode Island. Funded in part by a Cares Act Grant, the Linn Health Navigator acts as a source of information and referral agent in the local marketplace area, identifying needs and solutions before the consumer's condition deteriorates. Long term care providers need to get out in front of this endemic loneliness by reaching out to and engaging with the age-qualified population in their marketplace areas.

As early as 2002, loneliness among the elderly was recognized as a serious public health problem; the pandemic made this worse, and trends in housing are piling on.

Relocation among the aged, despite a short-term effect of the pandemic, has been declining and is now perhaps as low as 5% nationwide. [ii] Certainly, destinations like the Carolinas Pennsylvania, Florida, California, and Arizona will see net inward migration rates higher than this, but this is the nature of averages! In enormous proportion (and therefore numbers) the elderly will remain in their primary residences.

One author noted: [iii]

"Between 2020 and 2030, the number of households is set to rise by around 2m to 30.7m, but 35 per cent of the increase will comprise older households and, of these, 61 per cent will be one-person. The outlook is similar for 2030 to 2040, with further growth of 1.6m in the number of households to 32.3m, with 38 per cent of the additions forecast to be older households, of which 67 per cent will be one-person. Without any change, this spells a very inefficient use of the housing stock, not to mention the health and social care implications of so many older, often frail, people living alone."

The health and social implications of so many elderly living alone will create news-cycle narratives which simply cannot not be ignored.

The health and social implications of so many elderly living alone will create news-cycle narratives which simply cannot not be ignored. There will be more and more elderly seeking paid work outside the home, and other forms of community and social engagement. The "reserve army of the retired" will become the warriors of the care economy. One glaring shortcoming is that most urban and suburban environments are certainly not "age friendly." Furthermore, the current age and means-targeted transportation infrastructure is woefully inadequate.

There's an enormous amount of work to be done, and we must not waste time deflecting frivolous or self-dealing calls for eliminating nursing homes or preposterous suggestions that home care is the answer to everything. Please join me and others who are trying to develop serious and responsible dialogue. Contact me today and we will learn together what can be done in your neighborhood!

[i] The Forgotten Middle: Many Middle-Income Seniors Will Have Insufficient Resources For Housing And Health Care. Caroline F. Pearson, Charlene C. Quinn, Sai Loganathan, A. Rupa Datta, Beth Burnham Mace, and David C. Grabowski. Health Affairs 2019 38:5

[ii] A prior study in 2009 at UNC reported the level of age-qualified migration at 9%

[iii] Goodheart, C. and Pradhan, M. The Great Demographic Reversal: Ageing Societies, Waning Inequality, and an Inflation Revival. 1st ed. 2020. Palgrave MacMillan

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Ornstein

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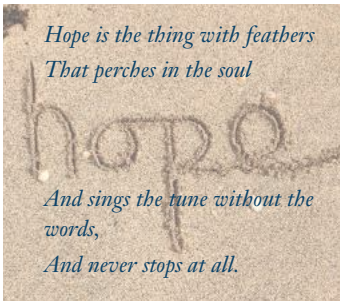
determine whether the violations had been addressed and corrected and are being maintained on an ongoing basis.

It is my hope these suggestions will benefit future nurse administrators as well as the lay public who reads this article and who may have a loved one in a nursing facility. It is also my hope that our nursing facilities will continue moving in a direction that enhances optimal patient care and results in family satisfaction.

The family's decision for admitting their loved one was based on the assurance that the patient will be cared for in a safe and respectful environment. To my professional colleagues whether in a nursing facility, a hospital, home health agency, or those who are in positions of authority, it is your duty to continuously perpetuate the concept of hope to those who are less fortunate.

The poet Emily Dickinson expresses it best:



In 1959 Dr. Sheldon Ornstein received his nursing diploma from the Mills-Bellevue Schools of Nursing becoming a registered professional nurse. He continued to earn several degrees including a Post Masters Certificate in Gerontology from Yeshiva University in 1979 and a Doctor of Education in Nursing Organization from Columbia University in 1997. He began his clinical career as head nurse on a rehabilitation unit, and nurse educator providing in-service education and clinical instruction for Nursing students and colleagues alike. He taught at several colleges and was an adjunct professor at Hunter College. Over the course of a 50+ year career, he held the position of Director of Nursing Services in long term care facilities before retiring in September of 2010 as Distinguished Lecturer/Associate Professor in the Department of Nursing at Lehman College, CUNY in the Bronx.

Meeting the COVID-19 Vaccination federal mandate for your facility

Continued from page 3

workers including employees, independent contractors, volunteers and providers of goods and services engaged in work in healthcare. All employees, whether they are licensed or not, are required to be vaccinated. The regulations also require all contractors, regardless of the type of work they perform (vendor, agency nurse, etc.), volunteers (such as those helping with activities or entertainers), and other health care providers (like home health, hospice, or therapy) to be vaccinated as well.

3. Exemptions

There are two situations in which an employee can become exempt from showing proof of vaccination: medical reasons and religious reasons. In both instances, the skilled nursing facility is responsible to offer reasonable accommodations (further as discussed in #4 below).

A. Medical exemption

An employee seeking a medical exemption must submit some form of documentation from their health care provider. HHI recommends utilizing a COVID-19 exemption status form.

- Employers need to rely on health care professional's advice and can seek clarification only.
- Employers can require the employee to become vaccinated if there is a direct threat, and no reasonable accommodation reduces that threat, or the accommodation causes undue hardship to the employer ("an action requiring significant difficulty or expense").
- Employers must process the exemption request even when it is anticipated that known reasonable accommodations are not feasible.

B. Religious exemption

Religion is broadly defined as "all aspects of religious observance and practice as well as belief" that is:

- New or uncommon beliefs
- Beliefs not hard for a formal church or sect, only subscribed to by a small number of people
- "Religious" even if the employee is affiliated with a religious group that does not espouse the same beliefs, observances, or practices, or if a few or no other people adhere to the same beliefs
- The employee must show a "sincere and meaningful" belief.
- The employer must assume that a request is based on sincerely held religious beliefs.
- The employer may request supporting documentation if the employer has a "bona fide doubt" or an "objective basis" for questioning the religious nature or sincerity of the belief, or verification from a third party does not have to come from a clergy member or fellow congregant; a first-hand explanation may be sufficient
- The employer can require vaccination if no reasonable accommodation can be provided without undue hardship to the employer ("more than a de minimis" cost or burden).

Challenging the religious exemption is a very difficult en-

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deavor. HHI recommends caution and to seek legal counsel if this type of situation arises in your facility.

4. Reasonable accommodations

Employers must provide reasonable accommodations to employees with:

- Disabilities
- Pregnancy that prevents them from being vaccinated
- Closely held religious beliefs that prevent them from being vaccinated.

The employer must engage in the "interactive process" with the person requesting the exemption. This means that the designated staff person should gather information on the request for exemption, discuss the request with employee, consider possible accommodations, and then decide what, if any, accommodations to provide and document the entire process with a letter to the employee.

The letter should include:

- Acknowledging the staff person's request
- Mentioning conversations that occurred
- Stating decision made
- Providing basis for decision.

In addition to the above-mentioned points for the letter, the employer must be diligent in:

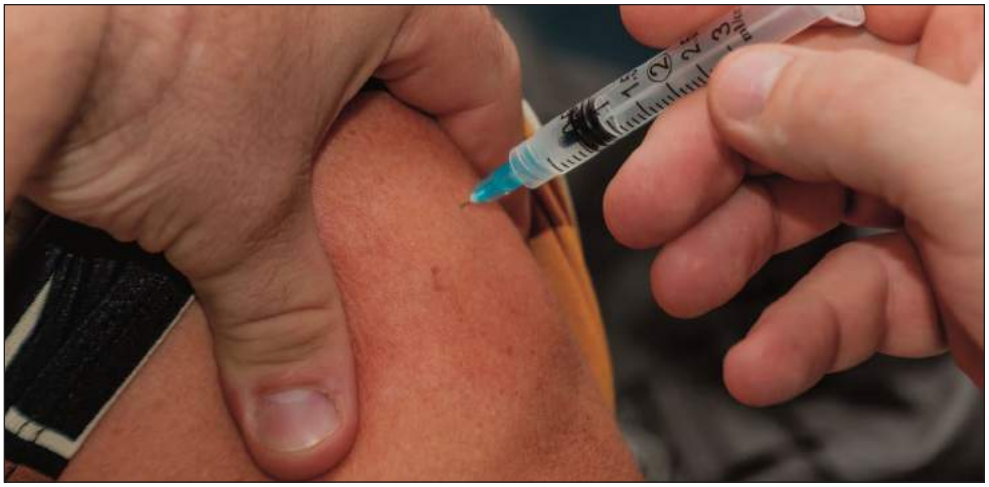
- Attaching all supporting documentation
- Maintaining confidentiality on both the staff person's vaccination status and reasonable accommodations provided.

Please note, the employer may exclude the employee from workplace while the decision is being determined.

Examples of Reasonable Accommodations:

- COVID-19 Testing: Requiring the employee to be COVID-19 tested on a weekly basis
- Enhanced PPE (personal protective equipment): Providing the employee with additional PPE for the employee to wear on a regular basis
- Working remotely: Allowing the employee to work in a remote setting; however, this may not be allowed if the employee has a role that is considered a direct care position
- New role or position: Offering the employee a different role in the organization

A final important component regarding reasonable accommodations is that the employer is equally responsible for providing



reasonable accommodations to all staff even if the staff is from a contract staffing agency or a vendor. These staff persons qualify for the same exemption and reasonable accommodations as in-house staff. This applies to any contractor regardless of the kind of work rendered.

5. Enforcement

The Department of Health, CMS and other state and federal agencies will be allowed to request proof of vaccination at any time. The protocol for any complaint will follow the normal complaint and investigation processes within the federal guidelines. Citations will fall under an F-Tag.

6. Requirements of Participation (RoP) Medicare and Medicaid programs

The federal COVID-19 vaccination staff mandate requiring all workers to be fully vaccinated against COVID-19 will be a condition of participating in the Medicare and Medicaid programs and necessary to receive funding.

7. COVID-19 vaccine policy elements

Drafting a COVID-19 vaccine policy is the first and most important step that each provider should initiate immediately. Key elements to be highlighted in the policy should include, but not limited to:

- The effective date of the required vaccination including specifying the date in which the last dose can be given in order to meet the deadline
- Clearly identify exactly who must be vaccinated
- Describe where the employees can obtain the COVID-19 vaccine
- Outline the COVID-19 Vaccine verification requirements and process
- Pay and paid time off (further as discussed in #7 below)
- Consequences of not being vaccinated
- Reasonable accommodations statement and practice
- Safety protocols

8. Hiring New Employees

- Do not request for proof of vaccination before person is officially hired.
- Do not request proof of vaccination during the interview.
- Be sure that the offer for employment only exists if the employee provides proof of vaccination. This proof is expected as soon as the candidate accepts employment.
- The employment offer should be contingent upon obtaining full vaccination or an exemption.
- New hire must provide proof of vaccination as soon as they accept the offer.
- Offer delayed start date for unvaccinated new hires. (May offer a bonus contingent upon vaccination combined with a predetermined period of work.)

9. Proof (verification)

There are only three mechanisms that employers can accept as documentation to verify vaccination. Employers must obtain one of the following three documents for proof of vaccination:

A. Copy or photo of CDC vaccination card
B. Documentation from a health care provider or electronic health record
C. Documentation from the state immunization information system

10. Vaccination records

Vaccination records are confidential medical records which means they must be maintained in a confidential manner. HHI recommends assigning a small group of people for the process of verifying documenting and maintaining these records. Begin thinking about the process and identifying all of the groups of people that need to be vaccinated.

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11. Data storage

Providers must Identify the individual or team responsible for data storage (including viewing, maintaining, and gathering the proof of vaccination records) for all individuals while ensuring that information is stored in a confidential location with restricted access.

HHI recommends maintaining a log (that keeps track of the proof) that is also stored in a separate and confidential location. If the log is saved on a server, ensure that it is located in a private folder with restricted access.

This database of information stores the details for all the individuals that the provider has obtained proof of COVID-19 vaccination or the documentation supporting a reasonable accommodation. This method is critical for access when and if a state or federal agency requests provider systems proof or if the provider if responding to a complaint investigation.

Currently, there is no electronic system that allows employers to verify vaccination.

12. Verification process

Another key element in this COVID-19 Vaccination process is to establish procedures for monitoring, tracking, viewing, and maintaining records of verification documents.

Draft policies identifying the designated staff person/department who will:

- Verify COVID-19 vaccination
- Maintain confidential storage of all records
- Implement a log to easily track individuals who have provided proof of vaccination
- Notify employees, con-

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Persons	Vax Verification Process
Employees	• Employee provides copy before defined date • Reasonable accommodations must be provided
Contractors	• Contracting entity provides proof before visit • Check-ins point for all others • Reasonable accommodations should be handled by contractor, may require community participation for health care professional from staffing agency
Volunteers	• Volunteer agencies provide proof before visit • Volunteer schedules time to provide verification • Check-ins point for all others • Reasonable accommodations must be provided
Other Health Care Providers	• Health care professional schedules time to provide, when possible • Check-ins point for all others • Reasonable accommodations must be provided

Continued from preceding page

tractors, volunteers, and other health care provide on the requirements for vaccination

- Communicate to employees, contractors, volunteers, and other health care provide how they must provide proof of vaccination (prior to visit or start of visit)
- Establish a check-in process at all facility entrances
- Confirm all entering individuals are either a visitor or have provided proof of vaccination
- Implement a process for handling Individuals who are not visitors and who have not provided proof of vaccination

13. Employee pay and employee paid time off for getting vaccinated

Employees must pay current employees for time spent receiving the mandatory COVID-19 vaccine. There are multiple different configurations to handle this requirement and attention is best used by customizing employee pay to the facility-specific benefits. A few options discussed below include the OSHA Reasonable Time Off Requirement and COVID-19 Vaccine Time Bank.

OSHA Reasonable Time Off Requirement

The OSHA Guidelines discuss allowing employees to obtain the COVID-19 vaccination during working hours. In theses instances, be mindful of managing the timing of vaccinations to prevent scheduling conflicts and a deficit of staff to provide care and services.

Per OSHA, the reasonable time off hours for each COVID-19 shot:

4 hours per COVID-19 shot to schedule, travel to and from, and receive vaccination

8 hours per COVID-19 shot for time off due to side effects from vaccination

These times should not be included in overtime calculations

COVID-19 Vaccine Time Bank

A separate COVID-19 vaccination time bank is not required, however, if the employer requires employees to use existing hours of paid sick time or vacation time, then these hours will need to be tracked. In addition, the employer must ensure that individuals without 8 hours available in their benefit package, still receive 8 hours per shot to recover.

14. American Rescue Plan Act (ARPA)

The ARPA extended the Families First Coronavirus Response Act (FFCRA) from April 1, 2021 through September 30, 2021 to qualifying employers that voluntarily chose to continue to provide Emergency Paid Sick Leave (EPSL) or Emergency Paid Family Leave (EPFL).

The FFCRA required entities (other than health care providers) to provide paid emergency sick leave for quarantining or isolating staff related to COVID-19 expanded to include COVID-19 vaccination time

- Up to 10 days of paid leave to obtain and recover from COVID-19 vaccination
- Applies to employers with fewer than 500 employees

The FFCRA has required a covered employer to provide a minimum amount of paid time off for EPSL for one of five pandemic-related reasons:

- The employee is subject to a government quarantine or isolation order.
- The employee is advised by a health care professional to self-quarantine.
- The employee is experiencing COVID-19 symptoms and seeking a medical diagnosis.
- The employee is caring for an individual who is subject to a government quarantine or isolation order, or who has been advised to self-quarantine by a health care professional.
- The employee is caring for a son or daughter whose school or place of care has been closed or whose child-care provider is unavailable.

The ARPA has created broader coverage for these categories. Specifically, with respect to one through three above, an employee is entitled to full payment (100 percent) of his or her daily wages, up to $511 per day and the tax credit will likewise be provided for wages paid up to $511 per day. With respect to four and five, an employee is entitled to payment that is at least two-thirds of his or her daily wages, at least up to $200 per day and the tax credit will likewise be provided for wages paid up to $200 per day.

The ARPA has expanded the reasons for which an employer must provide EPFL. The expanded reasons include:

- Employee is seeking or awaiting the results of a diagnostic test for, or a medical diagnosis of COVID–19
- Employee has been exposed to COVID–19
- Employer has requested such test or diagnosis
- Employee is obtaining immunization related to COVID–19
- Employee is recovering from any injury, disability, illness, or condition related to such immunization after a public health emergency

It is voluntary but employers who offer this are eligible for tax credits to cover the cost of the time of staff getting vaccinated. In these instances, it is suggested that the employer allocate a separate mechanism to track dollars related to getting and recovering from the COVID-19 vaccine.

15. Non-COVID-19 vaccinated employees consequences

For those employees that are not yet COVID-19 vaccinated and do not have a medical or religious exemption, the employer has two options:

- Place the employee on leave
- Terminate the employee

Leave of absence

For those employees who are not yet vaccinated and do not have a medical or religious exemption, employers should engage in a conversation to explore the rationale for non-vaccination. The employer may find many contributing factors such as, scheduling issues, recent COVID diagnoses (thus too soon to obtain vaccination), no access to an appointment, or even minimal to no access to a physician.

In these instances, in which employees are actively demonstrating an effort to obtain vaccination, the employer can place the employee on leave while the process evolves. This allows the employer to maintain a positive connection with the employee and affords a seamless and expeditious return to work when the vaccination is received.

Termination or leave

For those employees who are not yet vaccinated, who do not have a medical or religious exemption, and who are not demonstrating any attempt to discuss, resolve, or obtain a vaccination, the employer can place the employee on leave or terminate the employee.

Choosing the option to place this type of employee on leave reinforces the provider's relationship to the employee, maintains the rapport, and provides the employer an opportunity to rehire the employee, if and when, the mandatory vaccination requirement changes.

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.

A message from ACHCA leadership

Statement regarding COVID-19 vaccinations

The American College of Health Care Administrators (ACHCA) is grateful for the current administration's efforts to mandate vaccinations in long-term care settings to protect the elders and adults we serve every day. We do not believe, however, this course of action is encompassing enough to have the desired effect by targeting only nursing home and skilled nursing facility settings.

We believe the approach from the Biden administration and the Department of Health and Human Services (DHHS) should make the vaccine mandatory for all health care employees in all settings along the continuum of care, including other care settings reimbursed through the Medicare and Medicaid programs. We are gravely concerned that this new mandate will only serve to perpetuate and exacerbate the critical workforce shortage the long-term care industry is currently experiencing.

Preliminary evidence already suggests a departure of essential caregivers (e.g., CNAs, nurses) who diligently work to care for residents in care settings. Providing high-quality care to ur residents requires a substantial and dedicated workforce, and we are concerned that this mandate will lead long-term care workers to leave the industry to other health care settings, including those reimbursed through Medicare and Medicaid, where the vaccine has not been mandated.

We strongly urge the administration and DHHS to carefully consider a broad vaccine mandate policy to assure the unintended effects of mass staff departures do not negatively affect the care and services provided to older adults in nursing homes and skilled nursing facilities across the country.

We would welcome additional conversations on this matter and willingly offer to work with the administration to promulgate new standards to address this very important issue.

Existential challenges

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of the existential circumstances in which residential and other adult health services find themselves.

The Medicare Payment Advisory Council (MEDPAC) seems to understand that there is a problem. In July 2020 it told Congress that in 2018 the overall margin for freestanding nursing homes was negative for the first time since 1999. And in March of this year, it recommended that the SNF Value Based Purchasing Program be halted. The program was removing total dollars from SNF payments and not meeting its goals. An optimist may see in these actions a willingness by an important national regulatory advisor to seek some sort of real solution.

These ideas are something to think about. Integrating services may be one way to provide a service and payment model that will better meet the needs of older New Englanders while providing the financial stability that SNFS and most other elder health providers need to continue.

ACHCA MA CHAPTER

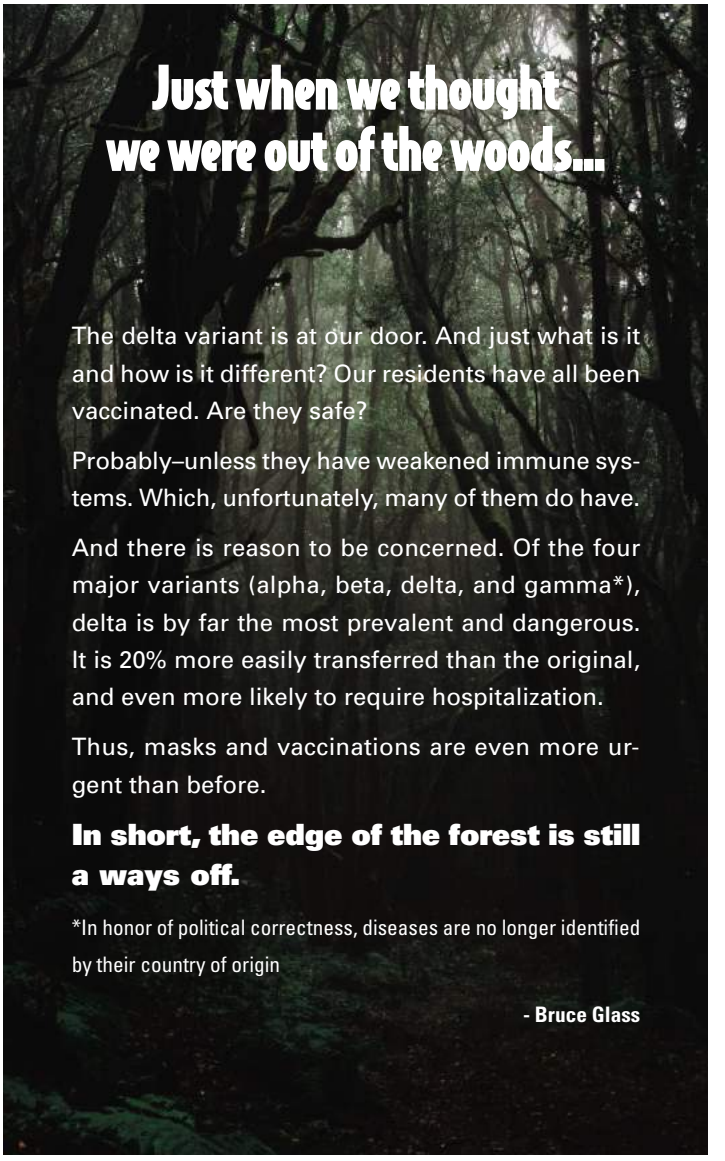
Stephen Esdale Memorial Golf Tournament

September 14, 2021
Olde Scotland Links, Bridgewater

Annual Conference & Trade Show

November 3, 2021
Gillette Stadium, Foxboro

For more details: achca-machapter.org



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