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SPECIAL EDITION
BUILDING BRIDGES BETWEEN INFECTION PREVENTION/EPIDEMIOLOGY,
SCIENTIFIC R&D, MANUFACTURING AND REGULATORY/COMPLIANCE

Long-Term Care in the COVID Era:

Mandates for Change, Opportunities for Improvement Driving the Way Forward

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contents

SPECIAL EDITION: LTC Imperatives Special Issue 2021

Cover Story

Columns

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from the editor

Moving Long-Term Care to the Forefront

As the daughter of a nurse, and someone who worked as a CNA in a SNF during high school and college in the late 1980s, I have immense love and respect for the long-term care profession and the residents it serves. It pained me greatly to see the unprecedented levels of misery not only in nursing homes but in all types of healthcare institutions as the COVID-19 pandemic worsened existing challenges and presented new ones that overwhelmed even the most prepared facilities.

A bright spot, if it may be characterized as such, is that out of tragedy can come opportunity. Long-term care has emerged from the shadows and may finally have a shot at garnering the recognition it deserves and the resourcing it needs to improve quality of care for residents and address critical staffing-related deficits. The world stage of healthcare has been in the spotlight because of the pandemic, and long-term care must leverage this visibility to foster meaningful and lasting change.

> *"Long-term care has come out of the shadows and may finally have a shot at garnering the recognition it deserves and the resourcing it needs to improve quality of care for residents and address critical staffing-related deficits."*

One of the joys of my position is meeting new people of like minds when it comes to commitment to service, and so it is a privilege to work with NADONA leadership like executive director Sherrie Dornberger to share with each other the knowledge of our respective organizations for the benefit of our collective audience of acute-care and post-acute care professionals.

This special issue you are reading now is designed to build bridges between our two readerships and celebrate the chance to begin new dialogue between sectors for the benefit of patients and residents everywhere. We are excited to feature a regular column in our publication penned by Cindy Fronning, NADONA's director of education, and we hope you will consider registering for our jointly organized webinar series on long-term care imperatives scheduled for this fall; see more details on page 14.

Healthcare Hygiene magazine is thrilled to be a first-time exhibitor at this year's NADONA annual conference, and we hope you will stop by booth 319 if you will be attending. I would love to meet you and hear your experiences about infection prevention, so that we may gain a better understanding of how we can bring to light the ongoing issues that need more attention. There has never been a better time to move long-term care to the forefront, and we look forward to being a NADONA partner and supporter.

See you in Niagara Falls Aug. 7-11!

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The Infection Preventionist in Long-Term Care: With Whom Will You Fill the Role?

By Cindy Fronning, RN, GERO–BC, IP–BC, AS–BC, RAC–CT, CDONA, FACDONA

The IP position involves many different roles.

They include leader, critical thinker, communicator, educator and collaborator.

These roles often intersect and combine throughout the IP's day.

Each of these roles are necessary to the IP being successful in this position.

In 2016 the new Rules of Participation were issued. There were many changes with three different start dates: Nov. 28, 2016; Nov. 28, 2017; and Nov. 28, 2019. In November 2019, the new rule for infection preventionists (IPs) became effective. It stated that:

- The facility must designate one or more individuals as the IP who is responsible for the facility's infection prevention and control (IP&C) program
- The IP works at least part time at the facility
- The IP has completed specialized training in infection prevention and control
- The IP must be a member of the QA&A committee and report to this committee regularly

There has been no additional guidance since the rule was finalized; however, there is promise of interpretations, but none have been forthcoming as of now. We do have the Infection Prevention, Control & Immunization survey task tool (CMS-20054) last revised in May 2021 that describes what the surveyors will be looking for. Unfortunately, not all long-term care facilities acted on this directive and were found in surveys to be in non-compliance by either not having an IP or the individual lacked the specialized training that was needed to be compliant.

Prior to November 2019, an article, "CMS Deadline Nears, But Infection Control in Long-Term Care a Challenge," was posted by Relias Media. It stated, "The IP position turned over within a year 39 percent of the time, and by two years, over half of them have left." It went on to say that all IPs responding to the study claimed at least one additional responsibility to their IP role, and some up to four additional roles.

This study also revealed that the most common reason for the IP turnover was a turnover in directors of nursing (DONs), with 55 percent reporting turnover in DONs and that brought new duties and expectations. Workload was the third reason for leaving.

A study by APIC quoted in this article stated, "Limited IP experience and turnover will pose a significant challenge for SNFs in trying to meet CMS mandates."

Margaret Drake, author of the previous study, also presented her research at the 2019 APIC annual conference. In that presentation she stated that IPs were "attempting to function in many leadership roles and very frequently are working on the floor as a nurse and a CNA. It is very typical for nursing leadership to go 13 to 16 days without a full day off. Typical days are 10 to 14 hours long."

With the arrival of COVID-19 and throughout the pandemic siege we have seen the IP position turnover rate increase, so, many administrators or DONs have had to hire several nurses into this position. With that in mind, how do we keep IPs in their positions and how do we hire the right ones?

When hiring an IP, what characteristics should the candidate possess? To determine that, let us look at what being an IP involves.

The IP position encompasses many different roles. They include leader, critical thinker, communicator, educator and collaborator. These roles often intersect and combine throughout the IP's day. Each of these roles are necessary to the IP being successful in this position.

As an effective leader, the IP administers the IP&C program through determining program priorities, responding to IP&C events and identifying and initiating performance improvement projects (PIPs). The IP advocates for resources for the program through interactions with administrative and clinical leadership and through the QA&A committee. The IP is accountable for the results of the program, shows integrity and has skills in organization and time management. Lastly, the IP must be able to challenge expectations and consider alternative viewpoints such as barriers to vaccinations by involving front-line staff in discussions to identify confusion and misunderstandings and attempt to educate and overcome these misconceptions.

As a critical thinker/data analyst, the IP uses the scientific evidence found in the literature and governmental guidance and translates it into practice. Performance and outcome surveillance data is used to determine IP&C activities. The IP will also use this data to shift priorities and resources when new issues arise, such as an outbreak or, as we have recently

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With the hiring of the right person and taking measures that once in the position, the IP has the confidence that they are a vital component to the facility and to program, will strengthen the position and retention of the IP.

witnessed, a pandemic. This could be implementing a new approach in using PPE, to suggesting that certain units be reserved for residents with specific infections such as COVID-19.

The IP role calls for a strong communicator. There is a need for robust written and verbal communication skills. The IP must be able to provide concise and accurate information to the various stakeholders (staff, residents, families, government agencies and organizational leaders) on a timely basis. The messages and methods of communication must be in a manner that is appropriate for the different audiences. This can vary from how performance surveillance results are relayed through posters and graphs in the break room, to informing the different entities of the COVID-19 outbreak results during the pandemic. How and what is reported to government agencies would need to be communicated to the residents and families in a different style and message content. The IP uses these strong communication skills when encouraging the staff to assist in identifying and implementing infection prevention interventions to IP&C issues.

Educator is another role about which the IP must be passionate. When we think of the word educator, the role of teacher comes to mind. The IP is teaching all day long. The IP interacts with a variety of audiences such as staff, residents, families and visitors. Bearing in mind who the IP is talking to helps the IP adapt the message to fit the background and learning needs of the person being addressed. The IP should be constantly cognizant of adult-learning principles. They include providing why this message and content is important, providing it in a style conducive to learning (visual, auditory and tactile), allowing them to experience what they have learned, the training must occur when the student is ready to learn, and it must be done in a positive and encouraging manner. Whether the IP is teaching in a classroom, in a huddle on the unit or in a "just-in-time" situation, content must be delivered with these concepts in mind. Education was and continues to be a huge focus of the IP during the pandemic and going forward.

When considering the last role of the IP, collaborator, we must consider what a collaborator is. Merriam Webster defines collaborator as someone who works with another person or group. With that definition in mind, the IP is a natural selection to be the liaison within and outside of the facility. The IP works within the facility to build agreement and teams to support the IP&C activities and goals. Outside of the facility, the IP builds relationships to bring support and resources to the facility's IP&C program. This might include having the local health agency provide training to the facility staff on the need for PPE and its proper usage. Or inviting the pharmacist and medical director to work with a subcommittee to develop antibiotic standard orders based on the facility's antibiogram.

When interviewing for an IP, keep in mind the different roles that the IP must fulfill. Tailor the interview questions to include these areas. Find out what the applicant believes their strengths and weaknesses are in these roles. Select your new IP knowing that you have these roles covered and provide the new IP with additional training if needed to ensure that you are meeting the Rules of Participation.

When incorporating these different roles of the IP into your selection process, the potential of a successful IP&C program and the retention of the IP increases. Both a win-win for your IP and your facility. But that is only the first step in reversing this turnover trend in IPs.

The following steps may assist in decreasing turnover as well:

- Making the IP a key position in the facility is extremely important to retaining this individual.
- Ensuring there is enough time dedicated to this role can ensure that the program gets the attention it deserves as well as an indication to the IP and the other staff that infection prevention is a priority for the facility.
- Providing clear direction regarding expectations of the role and how those expectations can be met within the timeframe allotted for the IP role.
- Lastly, ensuring those expectations are communicated to new leadership, should that occur, to provide consistency in the role.

With the hiring of the right person and taking measures that, once in the position, the IP has the confidence that they are a vital component to the facility and to program, will strengthen the position and retention of the IP.

Cindy Fronning, RN, GERO-BC, IP-BC, AS-BC, RAC-CT, CDONA, FACDONA, is a master trainer and director of education for the National Association of Directors of Nursing Administration in Long-Term Care (NADONA).

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Now is the Time to Reimagine and Reinvest in America's Nursing Homes

By Holly Harmon, RN, MBA, LNHA, FACHCA

The COVID-19 pandemic exposed and exacerbated systemic issues in America's long-term care system, such as workforce shortages and chronic underfunding. More than 5 million seniors and individuals with disabilities each year rely on the round-the-clock care and enriching social environment in long-term care facilities. They deserve the highest quality care, and long-term care profession officials are calling for meaningful, bold reforms.

The American Health Care Association, along with LeadingAge, have proposed the Care For Our Seniors Act to address some of the long-standing issues in America's nursing homes and continue our ongoing effort to improve the overall quality of care and services. There are four main principles that encompass these bold reforms – Clinical, Workforce, Oversight, and Structural. Many of their elements are designed to directly improve infection prevention and control.

To enhance the quality of care and services in nursing homes, the clinical principle outlines the need to develop robust standards for infection preventionists (IPs), require that each nursing home have a registered nurse (RN) on staff 24 hours per day, and require a minimum 30-day supply of personal protective equipment (PPE) in all nursing homes.

While some nursing homes have designated one or more part-time, specially trained IPs, others have full-time IPs, or have the position fulfill a broader role, with duties such as staff educator or supervisor. Prior to COVID-19, nursing homes already experienced a nationwide shortage of RNs and other challenges in recruiting qualified staff, including IPs. The pandemic has only exacerbated these workforce challenges. The increased demand for resources and dedicated, specially trained IPs – which are most often fulfilled by an RN – have strained nursing homes.

We have proposed creating an enhanced standard for staffing infection preventionists in each nursing home where the amount of time required for an IP is correlated with meaningful clinical and environmental factors. To effectively implement these changes, proper funding and key steps to increase workforce availability are necessary.

RNs play a critical role in ensuring nursing home residents receive the highest quality care. They help oversee and manage duties of other clinical staff (e.g., licensed practical nurses and certified nursing assistants), prepare care plans for residents, monitor their health, communicate with physicians, and interact with families of residents, among many other duties. Research has consistently found that as resident acuity increases in nursing homes, a greater presence of physicians, nurse practitioners or RNs results in better resident outcomes and increased satisfaction.

Therefore, the Care for Our Seniors Act supports enhanced staffing for each nursing home to have a RN on staff 24 hours a day and provides recommendations on how to effectively implement this including key steps to increase the availability of RNs in nursing homes and proper funding to fulfill this enhanced staffing requirement.

During the pandemic, worldwide supply chain issues combined with soaring demand among every industry and individual left many nursing home providers scrambling to acquire and afford precious PPE. An adequate supply of PPE improves infection control outcomes and has the potential to reduce mortality rates associated with infection outbreaks.

The Care for Our Seniors Act proposes to require each nursing home to have a minimum 30-day supply of PPE for average conventional use, which will be supported by ongoing federal and state stockpiles.

Real, long-lasting transformation that will truly protect our residents requires a considerable investment in the long-term care profession. Nursing home providers embrace meaningful changes that can help our residents, our staff and our country. But it won't be possible without a commitment from policymakers to provide necessary and consistent funding support.

For too long, nursing homes have faced chronic Medicaid underfunding and unfunded government mandates, leaving many unable to afford enhancements in their care delivery, workforce and infrastructure. COVID-19 has exacerbated these economic challenges. Nursing homes have spent tens of billions responding to the pandemic, specifically PPE, testing, additional staff and bonus pay. Coupled with significant losses due to fewer new residents, the nursing home industry expects to lose $94 billion over the course of the pandemic (2020-2021).

As a healthcare provider that relies almost entirely on government reimbursement (Medicare and Medicaid), nursing homes cannot make substantial reforms on their own. They need the support of federal and state policymakers and resources.

We must not let something like the pandemic happen in long-term care ever again, and we must prepare for a growing elderly population. We need to and want to do better.

AHCA/NCAL is eager to work collaboratively with the Biden Administration and Congress to implement significant meaningful reforms that will protect and improve the lives of our nation's seniors.

Holly Harmon, RN, MBA, LNHA, FACHCA, is the vice president of quality, regulatory and clinical services for the American Health Care Association (AHCA).

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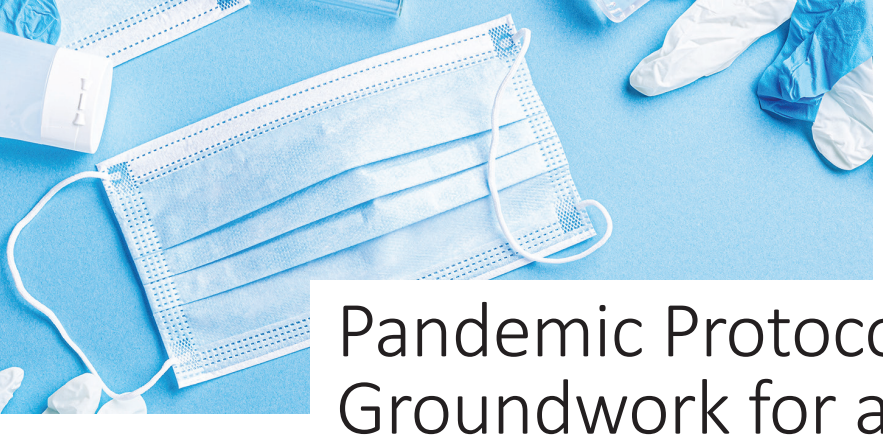

Pandemic Protocols: Laying the Groundwork for a Safer Future

By Buffy Lloyd–Krejci, DrPh, MS, CIC

The dawn I hope to see arise from this darkness is an industry that realizes the importance of infection prevention and control (IP&C), not only during a pandemic, but every day moving forward.

Yes, COVID-19 has hit the long-term care industry hard. Yes, we have been charged with a monumental task. Yes, many of us in healthcare have been pushed to or beyond our limits. I have personally been on-site in more than 160 nursing homes this past year, so I know and understand completely the dark times we are facing. I, too, have returned home from facilities and broken down in tears at the burdens and challenges and harms that are facing our industry. I am human.

But I also strive to be optimistic. As difficult as this may be in these arduous times, I choose to hold on tightly to the adage credited to English author Thomas Fuller, who in 1650 wrote these words: "It is always darkest just before the day dawneth." Whether Fuller composed these words himself, or he was documenting an ancient proverb are irrelevant to me, as I hold the meaning close.

The dawn I hope to see arise from this darkness is an industry that realizes the importance of infection prevention and control (IP&C), not only during a pandemic, but every day moving forward. An industry that takes IP&C and conveys its importance to every person who walks through the door of a long-term care facility, or any healthcare setting. An industry in which every staff member at every position in the building, clinical or not, has adequate training and resources to implement the best care possible for our residents and patients. The long-term care industry suffered great and tragic losses of residents and staff during the pandemic, but prior to this, the estimated numbers of deaths and harms due to infection in long-term care were still appalling.

C. diff, MRSA, and UTI are a few of the culprits. According to the CDC, 1 million to 3 million serious infections occur in nursing homes each year, resulting in an estimated 380,000 deaths caused by serious infections. When I first heard this unacceptable number about five years ago, I quit my corporate public health position and vowed to fight full-time to protect our residents and staff from these harms and deaths.

To me, IP&C are two entirely different things. Infection control implies the idea that the job belongs to one person, the expert we turn to during a crisis. Infection prevention bolsters the idea that this is everyone's responsibility, and that every chain in the link, every member of the team is responsible for best practices. If a deadly virus tragically taking hundreds of thousands of lives can have a silver lining, I believe the strict processes we are getting accustomed to will save just as many, if not more, lives in the future. You may have had a loved one lose his or her life from this virus in a healthcare setting, whether staff member or resident, and moving forward we must ensure that these lives lost were not in vain.

When it comes to IP&C, not all healthcare settings are created equal. Hospitals have had high standards and strict protocols for decades, including a highly trained, full-time infection preventionist (IP) on staff. But as more complex and acute care has begun to shift to settings outside the hospital, the strict protocols haven't followed. In late 2016, the guidelines for IP&C in nursing homes began to become stricter, with implementation to begin over time. As of November 2019, facilities were required to have an IP on staff. While the recognition of a problem is a good start, there were many snags in this new plan.

The IP&C protocols for a hospital and nursing home, while similar, do not identically transfer to the nursing home setting. The staffing and budgets for hospitals compared to nursing homes aren't even in the same ballpark. The hospital setting devotes a full-time, trained position to IP&C, while nursing homes scramble to assign the title and role to a current staff member, usually a director of nursing (DON) already buried in responsibility.

This isn't to say that they aren't willing, or they aren't strong enough to take on this additional responsibility, but even given all their effort they are unequipped to perform this additional role effectively. There exist plenty of IP&C training courses offered from credible, knowledgeable sources like the CDC and APIC, yet the bridge between information and implementation is long and difficult to traverse.

Each facility is unique, and while generalized instruction is a great start, the real-world application

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of the particulars is a different expertise. To say the least, the long-term care industry faces a myriad of challenges when it comes to keeping residents and staff, our loved ones, as safe as possible from harms and deaths due to infection.

During the height of the pandemic, while hospital quality surveys were suspended, CMS surveyors fined nursing homes more than $15 million in CMPs in the middle of their darkest hours. I wish to share the idea that this punitive system may not translate to the highest quality care for residents and staff. I get this mental image of firefighters showing up while your house is on fire, and instead of helping extinguish the fire, they issue you a fine for improper sprinkler installation. It sounds crazy, but to me, this is a sane comparison.

I would never want to be somebody who presented a problem without also opening the door to solutions, and this instance is no different. The long-term care industry needs support and specialized training, without the immediate monetary damages incurred. I understand the punishment for repeat offenders, but for most of these facilities, they are just trying their best to keep our loved ones safe while battling an invisible foe.

I see the path to change beginning with awareness, and so as I write this column, I am also finishing a book on this same topic. Let's get the conversation started. Let's brainstorm and rethink how we keep an entire generation of our loved ones as healthy and safe as possible.

To nursing home administrators and staff: There is help out there. Collaborative efforts with partners such as the quality improvement organizations offer support as they continue to better understand your challenges. But these programs will only meet your needs if you are willing to speak up and tell us loudly what you need. If you aren't heard, please be persistent. Tell us again and louder. We want to help.

Buffy J. Lloyd-Krejci, DrPH, MS, BS, CIC, has 20-plus years of healthcare experience, with expertise in quality improvement and healthcare-associated infections surveillance, statistical analysis, education, and training. She collaborates with the CDC long-term care team, state and national nursing home associations, local and state public health departments, and is an advisor on the EVS Optimization Playbook. She also served as 2019 Arizona APIC president.

Long-Term Care in the COVID Era: Mandates for Change, Opportunities for Improvement Driving the Way Forward

By Kelly M. Pyrek

Nowhere else in healthcare might you find a more challenging segment than long-term care (LTC), where approximately 1.3 million residents live in about 15,505 nursing homes in the United States (Fulmer, et al., 2020). Of these individuals, more than one-third experience dementia, and most have significant disabilities. They are primarily cared for by a low-paid, poorly trained workforce that must address a great heterogeneity of need and escalating acuity levels among long-term care residents.

Experts point out that even prior to COVID-19, the quality of nursing home care has long been a critical issue. In 1998, the Centers for Medicare and Medicaid Services (CMS) initiated the Nursing Home Compare website designed to help the public monitor clinical quality of nursing homes by providing long-term care facility performance measures, and which currently uses a five-star rating system. As of 2015, approximately 39 percent of U.S. nursing homes had overall low ratings of only one or two stars.

At the onset and then height of the COVID-19 pandemic, hard-hit U.S. nursing homes experienced high rates of morbidity and mortality, operating in full lockdown mode and fear of the coronavirus driving staff shortages that exacerbated other shortfalls in personal protective equipment (PPE) and resources to keep residents and caregivers safe.

Sharing what she has seen in nursing homes firsthand, Nancy Tuders, RN, IP-BC, GERO-BC, CDONA, a regional nurse consultant and regulatory specialist with Monarch Healthcare Management, recounts, "I would say we have very few residents prior to COVID-19 who were on droplet precautions; perhaps someone once in a while, but it was not routine. We also donned and doffed PPE in a different order than we normally practiced with other infectious diseases. That required ongoing return-demonstration education for all staff. Staff members were scared. So much was unknown and there was so much media coverage of people in ICUs dying from COVID-19. Staff were afraid they were going to die or bring it home to their families. Some staff quit their jobs. Residents were quarantined to their rooms. They ate their meals in their rooms. Their families were not allowed to visit. The hallways, common areas, and dining rooms were empty except for staff. That in and of itself was eerie. No matter how hard we tried, we could not stop COVID-19 from coming in. We had residents hospitalized and some died there. Others died at our facilities. Some staff became infected. Luckily, no staff who were diagnosed with COVID-19 were hospitalized. We had staff working double shifts regularly due to other staff being out sick. It was a daunting time. A sad and scary time. An exhausting time."

Tuders alludes to the moving goal posts of evidence-based guidelines being issued by public health authorities during the pandemic. "The guidance for care changed weekly, sometimes twice a week," she confirms. "That was extremely frustrating, but it was no one's fault. The WHO, CDC and CMS were trying to stay up to date but so much was unknown and changing regularly. We all were learning as we went along. I felt the media coverage was minimal in LTC unless you had several cases or deaths from COVID-19; then it was spun to appear you must be doing something wrong. In Minnesota where I work, we were so fortunate to have such great guidance and support from the different divisions of the Minnesota Department of Health (MDH). It immediately started – and still has – weekly calls to keep all providers updated on the latest recommendations and mandates. MDH was key in assisting facilities to make sure there was enough PPE at the peak of COVID-19. There were some lapses, and we did have to preserve at times, but MDH was diligent in trying to get needed supplies to us. The one exception was N95 masks, as they were all being used in the hospitals last year. LTC staff had to wear double masks or a mask and a face shield. That has recently changed, and we now have access to N95 masks, and they are used when providing care for a COVID-19 resident or suspected resident."

As Werner, et al. (2020) confirm, "U.S. nursing homes were unstable even before COVID-19 hit. They were like tinderboxes, ready to go up in flames with just a spark. The tragedy unfolding in nursing homes is the result of decades of neglect of long-term

care policy." They add, "Here, as in many other countries, nursing homes have been ill equipped to stop the spread of the virus. They lacked the resources necessary to contain the outbreak, including tests and personal protective equipment, and their staff are routinely underpaid and undertrained. Furthermore, nursing homes were sitting ducks for COVID-19, housing people who are particularly vulnerable to poor outcomes of the virus, often in shared living quarters and communal spaces, making social distancing or isolation difficult, if not impossible."

Just as the COVID-19 pandemic exposed an ongoing lack of preparedness in acute-care institutions, it aggravated the chronic obstacles to quality care in long-term care and other post-acute facilities.

Werner, et al. (2020) remind us that this crisis in nursing homes is not a new problem: "Long-term care in the United States has been marginalized for decades, leaving aging adults who can no longer care for themselves at home reliant on poorly funded and insufficiently monitored institutions. Although major regulatory policies, including the Federal Nursing Home Reform Act of 1987, have attempted to address deficiencies in the quality of care, COVID-19 has highlighted the fact that better monitoring is not enough. The coronavirus has exposed and amplified a long-standing and larger problem: our failure to value and invest in a safe and effective long-term care system."

In 1974, a U.S. Senate Special Committee on Aging report identified nursing home shortfalls: "Lack of human dignity; lack of activities; untrained and inadequate numbers of staff; ineffective inspections and enforcement; profiteering; lack of control on drugs; poor care; unsanitary conditions; poor food; poor fire protection and other hazards to life; excessive charges in addition to the daily rate; unnecessary or unauthorized use of restraints; negligence leading to death or injury; theft; lack of psychiatric care; untrained administrators; discrimination against minority groups; reprisals against those who complain; lack of dental care; advance notice of state inspections; false advertising."

There have been some significant changes in the years since, as skilled nursing facilities became more regulated due to the passage of the Nursing Home Reform Act, part of the Omnibus Reconciliation Act of 1987. The extensive standards established by OBRA 1987 were resident-focused and outcome-oriented, emphasizing quality of care, resident assessment, residents' rights, and quality of life.

However, much work remains, policy experts emphasize. In his March 6, 2019 testimony before the U.S. Senate Committee on Finance, David C. Grabowski, PhD, a professor in the Department of Health Care Policy at Harvard Medical School, noted, "Nursing home quality of care continues to be an important public policy issue despite prolonged public outcry and government commissions. Often the number of nurses per resident is low and the staff turnover rate is high. Residents may develop new health problems after admission from physical restraints and missed medications. There are studies documenting mistreatment of older adults in nursing homes. Amenities that are common within a nursing home – including the food, activities and public spaces – are too often sub-standard. The quality of life in many U.S. nursing homes is inadequate and large numbers of residents suffer from isolation and loneliness."

In May 2020, the Government Accountability Office (GAO) analyzed Centers for Medicare & Medicaid Services (CMS) nursing home infection prevention and control deficiency data, finding that prior to the COVID-19 pandemic, most nursing homes were cited for infection prevention and control deficiencies. About half of these homes had persistent problems and were cited across multiple years.

CMS is responsible for ensuring that approximately 15,500 nursing homes nationwide meet federal quality standards. These standards require, for example, that nursing homes establish and maintain an infection prevention and control program. CMS enters into agreements with state survey agencies to conduct surveys and investigations of the state's nursing homes and to cite nursing homes with deficiency citations if the home is not in compliance with federal standards. Infection prevention and control deficiencies cited by surveyors can include situations where nursing home staff did not regularly use proper hand hygiene or failed to implement preventive measures during an infectious disease outbreak, such as isolating sick residents. Many of these practices can be critical to preventing the spread of infectious diseases, including COVID-19.

GAO (2020) analysis of CMS data shows that infection prevention and control deficiencies were the most common type of deficiency cited in surveyed nursing homes, with most nursing homes having an infection prevention and control deficiency cited in one or more years from 2013 through 2017 (13,299 nursing homes, or 82 percent of all surveyed homes). In each year, GAO (2020) found that about 40 percent of surveyed nursing homes had infection prevention and control deficiencies, and this continued in 2018 and 2019. About half—6,427 of 13,299 (48 percent)—of the nursing homes with an infection prevention and control deficiency had this deficiency cited in multiple consecutive years from 2013 through 2017. This is an indicator of persistent problems at these nursing homes, the GAO (2020) says.

In each year from 2013 through 2017, nearly all infection prevention and control deficiencies (about 99 percent in each year) were classified by surveyors as not severe, meaning the surveyor determined that residents were not harmed. GAO (2020) review of CMS data shows that implemented enforcement actions for these deficiencies were typically rare; from 2013 through 2017, CMS implemented enforcement actions for 1 percent of these infection prevention and control deficiencies classified as not severe.

Pandemic-Driven Challenges

The American Health Care Association (AHCA) confirms that, "LTC facilities (including nursing homes and other congregate facilities for older adults) have been considered the epicenter of the pandemic, as more than 1 million cases and 170,000 deaths have been linked to these facilities across the country. Researchers tracking COVID-19 data in the United States and world-wide remained consistent in their findings in 2020. LTC residents made up a small percentage of total cases yet were a disproportionate share of each country's deaths. This research demonstrates the vicious nature of the virus on frail and elderly adults with comorbidities. Protecting older adults from this virus should have been our nation's top priority. It was not and, tragically, the seniors in our long-term care facilities were left behind. It is critical that we figure out what happened, why it happened, and what we can do to keep it from ever happening again. It is time for the country to decide if it will make sacrifices to help those who have sacrificed so much for us. It is time for bold, transformative, and meaningful action."

The independent Coronavirus Commission for Safety and Quality in Nursing Homes – which was tasked with assessing the response to the COVID-19 pandemic in nursing homes and made recommendations for additional actions CMS could take – reported recently that U.S. nursing home residents and staff represent only 8 percent of COVID-19 cases yet bear 41 percent of COVID-19 deaths based on data reported August 13.

A look at the medical literature also provides some sense of the magnitude of the morbidity and mortality associated with the COVID-19 pandemic in the LTC sector. In their review, Salcher-Konrad, et al. (2020) identified 54 study reports; outbreak investigations in LTC facilities found COVID-19 incidence rates of between 0.0 percent and 71.7 percent among residents and between 0.4 percent and 64.0 percent among staff at affected facilities. Mortality rates varied from 0.0 percent to 17.1 percent of all residents at outbreak facilities, with case fatality rates between 0.0 percent and 33.7 percent. In included studies of outbreaks, no LTC staff members had died. Studies of wider LTC populations found that between 0.4 percent and 40.8 percent of residents, and between 4.0 percent and 23.8 percent of staff were infected, although the generalizability of these studies is limited.

GAO analysis of Centers for Disease Control and Prevention (CDC) data shows that winter 2020 was marked by a significant surge in the number of COVID-19 cases and deaths for nursing home residents and staff. Specifically, during mid-December 2020, there were more than 33,600 new resident cases and 28,600 new staff cases, which was more than twice as high as the prior case number peaks in summer 2020. According to a GAO report (2021a), CDC data showed that cases and deaths in nursing homes are on the decline. Specifically, as of the week ending Feb. 7, 2021, resident and staff cases have both declined by more than 80 percent since their peaks in December 2020. The changing weekly COVID-19 death counts in nursing homes generally moved in the same direction as changes in the country. With the introduction of vaccines, observers are hopeful that nursing homes may be beginning to see a reprieve; however, the emergence of more highly transmissible virus variants warrants the need for continued vigilance, according to public health officials.

GAO analysis of data from the CDC shows that, from May 2020 through January 2021, nursing homes commonly experienced multiple COVID-19 outbreaks. According to CDC, an outbreak starts the week a nursing home reports a new resident or staff COVID-19 case and ends when there are two weeks with no new cases. GAO (2021b) found that nursing homes had an average of about three outbreaks during the review period, with most of the nursing homes (94 percent, or 12,555 of the 13,380 nursing homes) experiencing more than one COVID-19 outbreak.

For each nursing home's longest-lasting COVID-19 outbreak, GAO (2021b) found that about 85 percent (11,311 nursing homes) had outbreaks lasting five or more weeks. Conversely, for about 15 percent of nursing homes (2,005 homes), the longest outbreak was shorter in duration, lasting between one and four weeks, with 267 of those homes able to control their outbreaks after the initial week.

GAO (2021b) notes that its previous reports documented the numerous challenges nursing homes have faced in battling COVID-19, and adds, "While challenges related to staffing shortages have persisted through the pandemic, challenges related to obtaining PPE and conducting COVID-19 tests—although still notable—have generally shown signs of improvement since summer 2020. Further, with the decline in nursing home cases, CMS updated its guidance in March 2021 to expand resident visitation, an issue that has been an ongoing and persistent challenge during the pandemic. Some new challenges have also emerged as vaccinations started for nursing home residents and staff. Some of these challenges, such as staffing shortages, obtaining PPE, and conducting testing, are critically important for infection control."

Let us look at each issue.

Visitation

Through interviews with researchers, advocacy organizations, and national association officials from July 2020 to February 2021, GAO (2021b) reports that it consistently heard that "nursing homes have faced an ongoing tension between providing residents with important visitation and minimizing the potential for a COVID-19 outbreak." Specifically, the restriction of visitors has negatively affected residents' mental and physical health. Researchers and advocacy organizations have noted that the isolation resulting from decreased visitation can cause loneliness, anxiety and depression among residents. Additionally, the restriction of visitors has created limited oversight of facilities through the exclusion of resident advocates, such as family members and ombudsmen.

Staffing

In reviews of CDC data and interviews with advocacy organization and national association officials from July 2020 through January 2021, GAO (2021b) "consistently found that nursing home staffing challenges were difficult and ongoing throughout the pandemic." For example, CDC data from July through December 2020 consistently show that about 1 in 5 nursing homes were reporting that they had a shortage of nurse aides or other support staff. From nursing home associations that it interviewed, GAO heard that many alternative staffing sources have been used to fill critical gaps, such as seeking help from

Comparing Nursing Homes and Assisted-Living Facilities

Although assisted-living settings obviously differ from nursing homes in terms of the overriding model of care (such as the social versus medical model) and staffing (meaning lower staffing levels and less nursing care), it is interesting to look at illness and death rates from COVID-19. In assisted-living facilities, Thomas, et al. (2021) report that national all-cause mortality rates were significantly higher in 2020 compared with 2019 (an average of 2.30 versus 2.02 deaths per 1,000 residents per week; 17 percent higher overall mortality). During the peak week of April 8-14, 2020, assisted living resident mortality was 3.28 deaths per 1,000 residents per week compared with 2.24 deaths per 1,000 residents during the same week in 2019. New York had the greatest excess mortality between 2020 and 2019 (an average of 2.50 versus 1.57 deaths per 1,000 residents per week during January to August) followed by New Jersey (2020 versus 2019, 3.03 vs 2.09 deaths per 1,000 residents per week). Among the 10 states with the highest community spread during this period, excess mortality was 2.39 deaths per 1,000 residents per week in 2020 during January to August versus 1.93 deaths per 1,000 residents per week during January to August in 2019.

staffing agencies, sharing staff between other local providers, and using emergency waivers to hire nurse aides who had yet to complete their certification. As of January 2021, GAO continued to hear that staff are exhausted, face burn-out from emotional trauma, need to quarantine due to exposure to or illness from the virus, or stay home to take care of family members—all of which further strains staffing resources.

PPE

According to GAO (2021b) reviews of data from the CDC and interviews with advocacy organization and national association officials from July 2020 to January 2021, shortages of PPE in nursing homes have improved since the beginning of the COVID-19 pandemic but remain an issue. For example, CDC data show that, as recently as December 2020, about 10 percent of nursing homes did not have a one-week supply of at least one of the following: N95 respirators, surgical masks, gloves, eye protection, or gowns (a decrease from about 22 percent of nursing homes in July 2020). GAO heard that while challenges maintaining PPE supplies in reserve is an ongoing concern, supply shortages have become less severe over time.

Testing

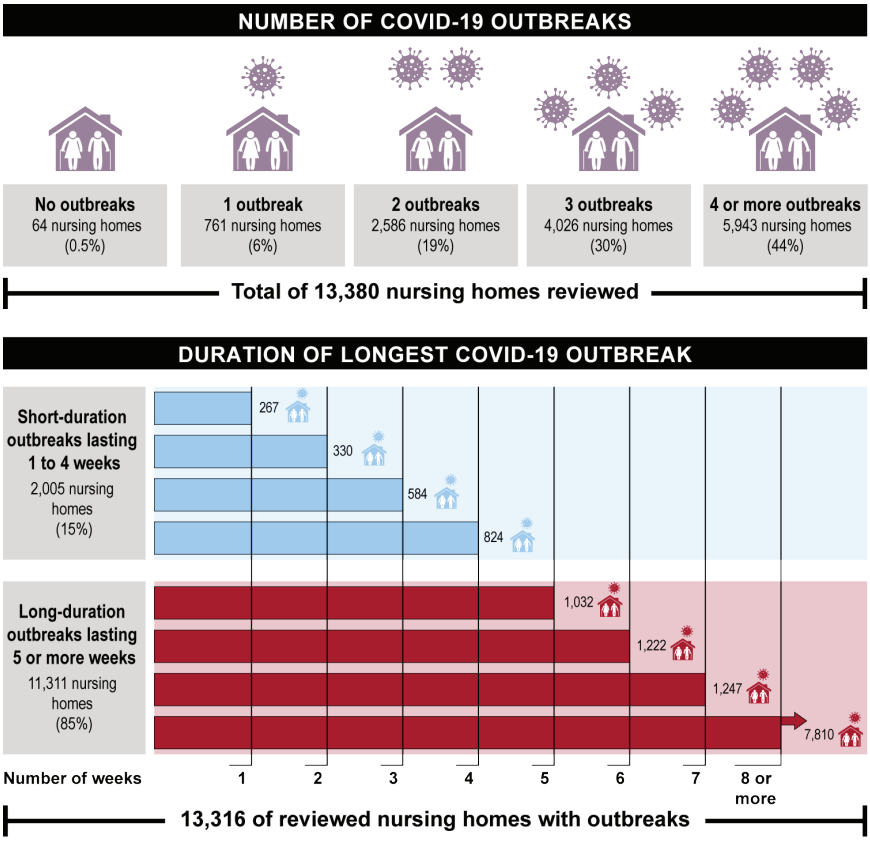
GAO (2021b) says that nursing homes' ability to use testing to identify infected residents and staff through testing protocols has improved over the course of the pandemic, but at a high cost to these facilities. Nursing homes have reported to CDC improved testing capacity; specifically, the number of nursing homes testing for COVID-19 in both staff and residents has increased by 48 percentage points—from 35 to 83 percent—between Aug. 16, 2020, and Nov. 22, 2020, the last week complete data for overall testing were available. Although data reported in December 2020 by nursing homes found that less than 2 percent of these facilities would be unable to test all staff or residents within the week if needed, nursing home association officials note that the high cost of continuous testing is not sustainable indefinitely.

Vaccination

GAO (2021b) notes that nursing homes face some emerging challenges related to vaccination efforts. A February 2021 CDC study estimated low rates of vaccine uptake among nursing home staff (38 percent) compared to nursing home residents (78 percent) participating in the Pharmacy Partnership for Long-Term Care Program. GAO says it heard about reluctance among some nursing home staff to receive the COVID-19 vaccine, in addition to hearing about uncertainty around certain aspects of vaccination distribution and requirements earlier in the year.

The Coronavirus Commission on Safety and Quality in Nursing Homes (2020) emphasizes the importance of balancing resident and staff safety and well-being in the wake of the pandemic: "Rigorous infection-control practice and treatment needs require that residents that test positive for COVID-19 may need to be transferred to new locations within their nursing home, to other sites, and in and out of hospitals. In the early days of the pandemic, transitions at times were abrupt, and the resident and family had no prior awareness that such a transition might occur. In the future, when a nursing home contends with a widespread outbreak, rapid transitions may still be indicated. When transitions are not well-communicated, the result may be that care is not coordinated or handoffs are missed. The resident and family suffer from the trauma that relocation and/or isolation may cause—from the possible decline in care quality, as well as from missed opportunities for resident-cen-

Figure 1: Number and Duration of COVID-19 Outbreaks in Nursing Homes, May 31, 2020, through January 31, 2021



Source: GAO analysis of Centers for Disease Control and Prevention data. | GAO-21-367

Data tables for Figure 1: Number and Duration of COVID-19 Outbreaks in Nursing Homes, May 31, 2020, through January 31, 2021

Number of COVID-19 outbreaks

	No outbreaks	1 outbreak	2 outbreaks	3 outbreaks	4 or more outbreaks
Number of nursing homes	64	761	2,586	4,026	5,943
Percentage of nursing homes	0.5	6	19	30	44

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-20-576R

tered shared decision-making. Furthermore, different funding streams and oversight authorities complicate matters for owners and administrators trying to understand to whom they should go for additional help. Well-intentioned incentives may inadvertently create unintended consequences, such as care paradigms that are not person-centered or person-driven. Because reimbursement rates are higher for placing residents with COVID-19 in a room alone (as compared to placing residents with a COVID-19 positive group), nursing homes administrators may be more likely to isolate residents prematurely, contrary to resident-expressed desires to remain with other residents with the same infection status. During an outbreak, there may be insufficient time and funding for additional staff training on COVID-19 and other infectious-disease protocols. And, with limited staff available on a day-to-day basis, surge support often is unavailable to nursing homes in times of crisis. Staff members, already stretched thin, become more taxed while working on the front lines of the crisis—and subjecting themselves and their families to increased risk of contracting the disease. Nursing home staff have been asked to deploy themselves and their limited resources in new ways and with Herculean effort—a scenario likely to exacerbate turnover and staff shortages in the long term."

"The most pressing issues currently are the need for staff and vaccination compliance," emphasizes consultant Nancy Tuders. "We still have COVID-19. I do not think the public is aware of that. We may have no cases for a week or two but then a resident or staff is positive. It has slowed down, but it is far from gone. We are still in face shields or goggles, masks, gowns and gloves. I believe the last numbers I saw was 40 percent of staff are vaccinated. Staff are leery of getting vaccinated. They say the vaccine was rushed through and not enough is known about the long-term side effects. Mandating staff to get the vaccine would increase resignations and the LTC industry is already in desperate need of more staff."

While significant pockets of need still exist in long-term care facilities, when it comes to pandemic response efforts, GAO points to how the Department of Health and Human Services (HHS), primarily through CMS and CDC, has taken a series of actions to address COVID-19 in nursing homes, such as providing guidance to these facilities on infection control practices and issuing waivers and regulatory flexibilities. For example, in March 2020 CMS waived the requirement that a nursing home not employ nurse aides for more than four months unless they meet certain training and certification requirements – a step taken to address potential staffing shortages. (GAO, 2021b)

Other actions included temporarily suspending state survey agencies' standard surveys and many complaint investigations, instead shifting to targeted infection prevention and control surveys and high-priority complaint investigations. On June 1, 2020, CMS issued survey re-prioritization guidance as part of its nursing home reopening strategy. Specifically, once a state enters phase 3—a threshold based on factors including case status in the community and the nursing home, as well as access to testing, PPE, and adequate staffing—state survey agencies were authorized to

Financially, assistance came from billions of dollars in payments from the Provider Relief Fund, established with funds provided under the CARES Act and other COVID–19 relief laws, as direct payments to assist nursing homes with responding to COVID–19.

As of Jan. 15, 2021, $5 billion in Provider Relief Funds had been allocated for nursing homes and $4.764 billion had been disbursed.

expand beyond conducting targeted infection control surveys and high-priority complaint investigations to include lower-priority complaint investigations. On Aug. 17, 2020, CMS revised this guidance to authorize traditional, comprehensive, standard surveys and lowerpriority complaint investigations as soon as state survey agencies have the resources, such as staff and PPE.

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Despite relief efforts, nursing homes are facing myriad challenges relating to post-pandemic imperatives.

"Low census is a concern, but I feel it is slowly improving," Tuders says. "Sufficient staff is also a challenge in many areas. The work is hard and the pay not stellar. I think with some of the unemployment expansions and other perks, many people are getting along just fine without a job. Before the pandemic we knew the requirement was coming for a trained infection preventionist, so we were preparing for that mandate. However, when COVID hit, it became our main focus. Many other priorities were no longer priorities, so we did have to scramble a bit earlier this year to assure compliance."

Ongoing pain points include helping nursing leadership survive and attempt to thrive in the "new normal" going forward.

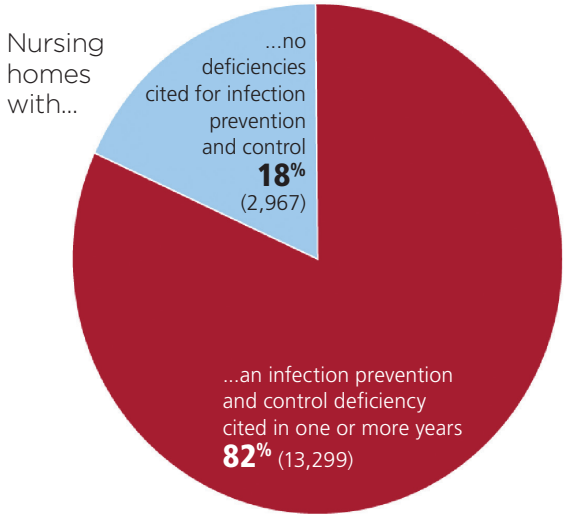
"We are trying to provide ongoing support for our leaders in the facilities," Tuders says. "They are multi-tasking like never before, trying to increase census, hire staff, monitor for COVID-19, get N95 masks test-fitted for new hires, be ready each day for any one of a multitude of surveys for licensure, a complaint that often was self-reported, their annual survey which is likely more than 20 months late and there is also a 20 percent chance a facility could receive an infection control survey under CMS guidance from last year. I do not think anyone in a leadership position in long-term care would say the survey environment is stress-free. It is tough."

Tuders continues, "My hat goes off to all the staff who work tirelessly in long-term care. They are juggling so many critical pieces when the world stood still for COVID-19. You must have energy, commitment, be able to multi-task, and most importantly have a sense of humor. I have found most people who work in long-term care do it for the love of the residents."

Tuders says that the pandemic provides an opportunity to move long-term care from being seen in a negative light to one in which it is better understood and appreciated.

"Long-term care has 500 regulations that must be met daily," she emphasizes. "The only other industry that is higher is nuclear power plants. We need respect and some understanding of the year we lost to COVID-19 when that was our main priority. I think the regulatory process could ease up a bit as we transition back into being able to focus on more than COVID-19 as our cases decrease and we begin to digest the fact this disease is the new normal. It feels to me the regulatory process has gotten more stringent than ever before and at a time when hiring staff is already a challenge. The work is physically demanding and often very stressful. It is not glamorous work but life-enriching. We lose staff to hospitals who can pay more due to the much higher reimbursement they receive; a battle it seems we will never win. If we truly want to provide the best care possible to our residents, we need to pay our staff better and look at some of the regulations to see if they are truly necessary. I would like to say thank you from the bottom of my heart to all those who have stayed the course for the residents they love – you are all true heroes."

Let us examine the issues facing long-term care in greater depth.



Source: GAO analysis of Centers for Medicare & Medicaid Services' (CMS) data. | GAO-20-576R

Clinical Challenges

It has been estimated that 1.6 to 3.8 million healthcare-associated infections (HAIs) occur in nursing homes annually. GAO, as well as the independent Coronavirus Commission for Safety and Quality in Nursing Homes and many others have affirmed the ongoing, systemic problems that underline the difficulties of preventing and treating infections in nursing homes.

Grabowski (2019) summarizes the causes of poor care practices: "In the context of staff shortages, nursing homes often use labor-saving practices to deliver care. These labor-saving practices are typically associated with a greater risk of morbidity and mortality. For example, managing incontinence maybe labor-intensive, through regularly scheduled toileting and bladder rehabilitation, or labor-saving through urethral catheterization. Urethral catheterization

places the resident at greater risk for urinary tract infection and long-term complications including bladder and renal stones, abcesses, and renal failure. Nursing homes face similar decisions with respect to feeding residents (hand feeding versus feeding tubes), and in monitoring and controlling residents' behavior (monitoring by staff versus physical or chemical restraints). Although antipsychotics are not appropriate for the majority of nursing home residents with dementia, nursing homes often use antipsychotics to 'manage' behavioral symptoms associated with dementia. Feeding tubes can result in complications including self-extubation, infections, aspiration, misplacement of the tube, and pain. Immobility resulting from physical restraints may increase the risk of pressure ulcers, depression, mental and physical deterioration, and mortality. Inappropriate use of antipsychotic medications may also result in mental and physical deterioration."

Grabowski (2019) also emphasizes that 16 percent of nursing homes were found to have at least one of the most severe deficiency citations from 2000 through 2007. These deficiency citations are for actual or potential for death or serious injury.

Risk assessment and management can guard against adverse events and poor outcomes in long-term care facilities.

In a recent presentation at the virtual annual conference of the Association for Professionals in Infection Prevention and Epidemiology (APIC), Marlene Fishman Wolpert, MPH, CIC, an infection preventionist at St. Joseph Health Services of RI, explained that types of risk assessment include a facility assessment; an Infection Control Assessment and Response (ICAR); an all-hazard approach IP&C risk assessment; an Infection Control Risk Assessment for Construction (ICRA); and a Waterborne Infection Control Risk Assessment (WICRA).

Wolpert says that the first step in implementing an all-hazard risk assessment is for the IP to work with the team on the facility assessment. The ICAR will then drive the all-hazard approach IP&C risk assessment, which then leads to the development of the facility's antimicrobial stewardship program. In turn, this drives the written infection control program goals and priorities. The ICRA logically guides construction projects, and the WICRA guides development of the facility's water-management plan.

As we know, CMS requires a risk assessment be conducted annually, and Wolpert points out that risk assessment is a common gap in nursing homes, particularly relating to management of multidrug-resistant organisms (MDROs), tuberculosis and influenza. Wolpert advises that for effective risk assessments, IPs should use an all-hazard approach and for each topic, think of how well staff are educated, and base your assessment on hazards during resident activities. She says to determine your resources to prevent transmission and development of infections and assign level of risk for infection occurrence and IP&C practice.

When determining the facility's risk assessment score, Wolpert identifies the following factors to consider:

1. Probability of occurrence:
- Prior infection levels
- Community frequency
- Effectiveness of prevention campaigns

2. Impact on resident care:
- Need for new treatment
- Change in level of care or support
- Restrictions on facility access

3. Level of harm from events:
- Past illness
- Hospital admissions
- Prior deaths
- Resident risk factors

4. Readiness to prevent the event:
- Surveillance to detect infection
- Performance monitoring
- Vaccination rates
- Adherence to sick-leave policies
- Visitors' adherence to cough etiquette
- Access to supplies/PPE
- Training/competency assessments

As we have seen, having an infection preventionist (IP) on staff is one of the strongest safeguards for resident care. In 2015, the federal government, through CMS, first proposed requiring each nursing home to designate one individual (a clinician who worked at least part-time) as the facility's IP. The American Health Care Association (AHCA) and LeadingAge supported this requirement and advised the Administration at the time that this professional would need to devote more time to the role. They suggested that CMS allow facilities to designate one or more individuals as IPs, so these professionals could cover for each other and work together during outbreaks. Those recommendations were reflected in the final rule, issued in October 2016, and went into effect November 2019. APIC is also looking to advocate for one full-time IP on the long-term care premises, at a minimum, as well as ensuring that the IP be board-certified in infection prevention and control and must create a surveillance plan for the facility.

The challenge is that IPs are concerned whether they have enough hours in accordance with CMS regulations. "CMS wants to know you are getting the job done," Wolpert says. To address this, Wolpert recommends that IPs in long-term care review their risk-assessment duties and priorities, checking for gaps in their facilities' IP&C programs. Wolpert confirms that CMS requires a designated IP who works "at least part-time at the facility," and that the IP must be qualified and have specialized infection control training.

"An IP is going to have plenty to do," confirms Deborah Burdsall, PhD, RN-BC, CIC, FAPIC, who also recently presented at the APIC virtual conference on an IP's role during and after the pandemic. Acknowledging the IP's need to pivot to a COVID-19 response, Burdsall noted that relationships developed during CDC Infection Control Infection and Response (ICAR) visits provided an established network that helped communication. However, long-term care facilities were severely challenged with an inadequate infection prevention and control infrastructure. She points to the fact that components of the 2016 "Mega Rule," in which CMS issued final regulations to modernize and strengthen existing Medicaid managed care rules, are now being implemented, including the requirement of a formalized IP role (F 882) as well as a structured focus on infection prevention and control programs (F 880–F 886).

These mandates could not come at a better time, as the top 10 citations, as of April 2021, Burdsall pointed out, included F0880 Infection Prevention & Control. The other top nine citations were, according to LeadingAge:

- F0886 COVID-19 Testing – Residents & Staff
- F0689 Free of Accident Hazards/Supervision/Devices
- F0684 Quality of Care

Staffing is a perennial challenge for all healthcare institutions, but it is particularly difficult in long–term care, where turnover rates for nursing homes range from 55% to 75%, and CNAs having turnover rates which in some cases are nearly 100%.

- F0580 Notify of Changes (Injury/Decline/Room, etc.)
- F0883 Influenza and Pneumococcal Immunizations
- F0885 Reporting – Residents, Representatives & Families
- F0686 Treatment/Services to Prevent/Heal Pressure Ulcers
- F0609 Reporting of Alleged Violations

One of the issues that became critical during the pandemic was the importance of routine, robust cleaning and disinfection in LTC facilities for the prevention of HAIs. In their site visits at 23 out of the 45 LTC facilities which reported COVID-19 infections, Telford, et al. (2020) found that overall, IP&C implementation was lowest in the disinfection category (33 percent) and highest in the screening category (75 percent). In the disinfection category, 61 percent of LTC facilities had a certified IP on staff and 26 percent were training and auditing staff on the proper use of cleaning products, including wet times and implementation of the two-step method. Cleaning logs documenting disinfection of shared items (IV polls, wheelchairs, shared blood pressure cuffs) were only present in 13 percent of LTC facilities. In the hand hygiene category, only 39 percent of LTC facilities had hand sanitizer available in all essential locations (nursing stations, medical carts, outside COVID units, in patient rooms). Protocols to enforce social distancing in small, enclosed spaces such as elevators or PPE donning and doffing rooms were established in 35 percent of LTC facilities. No nursing homes were implementing the Buddy System for donning and doffing PPE at the time of the researchers' site visits, which necessitates nursing staff observing each other through the PPE donning and doffing process.

Administrative and Staffing Challenges

Staffing is a perennial challenge for all healthcare institutions, but it is particularly difficult in long-term care, where turnover rates for nursing homes range from 55 percent to 75 percent, and CNAs having turnover rates which in some cases are nearly 100 percent. Retaining quality charge nurses is no less challenging, and now, with mandates for an infection preventionist, administrators are rethinking their workforce strategies.

As Grabowski (2019) affirms, "Labor is the dominant input into the production of nursing home care, accounting for roughly two-thirds of nursing home expenditures. Nursing homes are predominantly staffed by registered nurses (RNs), licensed practical nurses (LPNs) and certified nursing assistants (CNAs). Higher nursing home staffing has generally been found to be associated with better quality of care. Nursing homes with low staffing levels, especially low RN levels, tend to have higher rates of poor resident outcomes such as pressure ulcers, catheterization, lost ability to perform daily living activities, and depression. Staffing standards may also improve working conditions, which would increase job satisfaction and reduce nursing turnover and burnout. Nursing home staff, especially CNAs, have very high turnover. It is not uncommon for nursing homes to have their entire set of CNAs change multiple times within a calendar year. Research has found that nursing homes with higher staff turnover have worse quality."

The 2013 Commission on Long-Term Care emphasized that, "Nursing homes are hampered by too few staff, who are paid too little for physically and emotionally taxing work. Additionally, little room exists for these professionals to advance in their careers, and they suffer from a lack of meaningful benefits. As a result, challenges in workforce recruitment and retention are compounded year-over-year, as workforce shortages persist with the older population increasing. Without qualified staff, nursing homes find it difficult to meet residents' regular needs—let alone those that arise in times of crisis. Along with shortages in the workforce, some nursing home owners and administrators are limited in the resources at their disposal—hampering responses to emergencies regardless of whether they are natural disasters or infectious disease outbreaks. When crises arise, owners and administrators frequently do not have necessary training, equipment, or staff to respond. Often, nursing homes may be deemed lower-priority facilities for assistance from government sources in comparison to acute care settings. As a result, emergencies stress an already precarious care system." (Coronavirus Commission on Safety and Quality in Nursing Homes, 2020)

Fiscal Challenges

Long-term care is big business. Annual U.S. spending in 2018 on nursing homes was approximately $170 billion, with Medicare spending approximately $38 billion and Medicaid spending approximately $50 billion (CMS, 2019). What is important to remember is that long-term care facilities are paid under several different systems, and that these fragmented funding streams feature widely varying rates and myriad regulations. Some long-term care residents will stay less than 100 days, the point at which Medicare nursing home benefits generally end. These short-stay patients receive skilled nursing care, generally for either rehabilitation services after hospitalization or for palliative and hospice care at the end of life. Many more who reside in nursing homes for long periods have exhausted personal assets and rely on Medicaid for payment.

Experts agree widely that COVID-19 has exposed longstanding issues in how nursing home services are structured and financed, accounting for the perennial struggles to provide quality outcomes.

As Grabowski (2019) observes, "The way in which we regulate and oversee care quality, how we pay for nursing home services, how we regulate the supply of providers, and the inability of many residents to oversee and monitor their care all may contribute to low quality. When it comes to nursing home care, as the old saying goes, we get what we pay for. Due

in part to the exclusion of long-stay nursing home services from the Medicare benefit, Medicaid is the dominant payer of nursing home services, accounting for 50 percent of revenues and 70 percent of bed-days. Medicaid payment rates are typically 70 percent to 80 percent of private-pay prices. In many states, the average margins for Medicaid residents are negative, suggesting the cost of treating Medicaid residents exceeds the amount that Medicaid reimburses for their care."

As Grabowski and Mor (2020) explain, "Medicare is a relatively generous payor, whereas Medicaid often pays below the cost of caring for these frail and medically complex individuals. Thus, the economics of nursing home care hinges on admitting enough short-term Medicare beneficiaries to cross-subsidize the care of long-term residents with Medicaid coverage. Nursing homes that are predominantly dependent on the lower Medicaid reimbursement are poorly resourced, have lower staffing levels, are in poorer neighborhoods, have the most quality problems, and are most likely to close."

Werner, et al. (2020) address the changing utilization of long-term care facilities that could impact the fiscal health of the post-acute sector: "Nursing homes have seen decreasing occupancy for decades, despite the aging of the U.S. population. The number of patients discharged from the hospital to a nursing home for rehabilitation has also declined. To constrain healthcare spending, these patients are being sent directly home, which puts the squeeze on a critical part of nursing homes' revenue. Since the pandemic began, short stays have all but vanished, as nursing homes turn away patients after hospital discharge, fearful of an influx of patients with COVID-19. With Medicare's recent loosening of restrictions on the use of telehealth, it is increasingly possible to support recovery from hospitalization in patients' homes, and this approach will most likely outlast the pandemic. At the same time, states have been shifting Medicaid-funded care into people's homes, partially in response to a U.S. Supreme Court decision in Olmstead v. L.C. (1999) requiring that care be provided in the least restrictive setting possible. Since 2013, Medicaid has shifted a larger share of care into homes and out of nursing homes, even as it continues to underfund care in both settings."

Experts say that it is critical for Medicaid to pay a higher rate commensurate with the costs of delivering high-quality long-term care to frail older adults. As Grabowski and Mor (2020) note, "Long-term nursing home residents recovering from COVID-19 will require extensive medical and social care. In many states, this will require greater federal contributions. However, this will not be sufficient to ensure access to high-quality medical care for these individuals. Because Medicare still covers medical services for these long-term nursing home residents, models are needed that integrate medical care with the social needs of patients recovering from COVID-19."

Grabowski and Mor (2020) add, "More engagement of physicians and nurse practitioners in leadership positions in healthcare systems to provide population health to this challenging population is going to be key for any innovation to work because financing reform without delivery system reform is not going be successful. An increasing share of primary care delivered to residents in nursing homes is being provided by specialist clinicians, many of whom are nurse practitioners. This shift has coincided with a reduction in hospital transfers among long-term residents, which helps to make the new financing models viable because reducing hospitalizations makes possible more primary care and other services enhancing quality of life."

The COVID-19 pandemic has necessitated a paradigm shift, and as Werner, et al. (2020) assert, "We are well past due for comprehensive policies that take the care of aging Americans seriously and fund it accordingly and in a wider range of settings. In the short term, nursing homes will have to be saved, because despite their vulnerabilities, they are a necessary part of any solution. Some advocates estimate that it will take up to $15 billion in federal funds for nursing homes to survive the COVID-19 pandemic. Recent congressional relief packages have started to address the anticipated shortfall, although experts say they will not be enough. Beyond the pandemic, we will have to transform the way we pay for and provide long-term care. We believe that Medicaid programs need to invest considerably more in care in all settings. As Medicaid has shifted long-term care into homes, funding has not kept up with that trend, meaning that more is demanded of families, who are often responsible for providing informal, unpaid care. An adult child who cares for an aging parent will face losses equivalent to $100,000 a year, on average — roughly the same cost as a nursing-home stay. Policies that prioritize home-based care should ensure that it is paid for, whether it is provided by family members or professionals. Many families have wanted to provide care at home even before COVID-19, and after the pandemic many more may choose to do so if they can afford it… More funding alone is not the answer. Nor is more regulation a sufficient response. Rather, we need a combination of funding, regulation, and a new strategy that fully supports a range of institutional and noninstitutional care."

The Way Forward

Increasing organizational capacity to improve safety and quality is an imperative going forward.

As the Coronavirus Commission on Safety and Quality in Nursing Homes (2020) emphasizes, "During the pandemic and every day, nursing home staff are responsible for the care and protection of some of the most vulnerable populations in the nation. The safety and quality of life needs of residents are complex and diverse and require mindful decision-making and effective processes in order to be met. Mindful

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More funding alone is not the answer.

Nor is more regulation a sufficient response.

Rather, we need a combination of funding, regulation, and a new strategy that fully supports a range of institutional and noninstitutional care."

The American Health Care Association (AHCA) and LeadingAge assert that as nursing homes emerge from the pandemic, lawmakers must commit to substantive reform and support for the industry, and earlier this year have proposed the Care For Our Seniors Act – a reform package that will support better pandemic management and strengthen overall care in nursing homes.

decision-making is only possible when the workforce feels safe, prepared, and respected for the meaningful work they do. They need to work in facilities compliant with Occupational Safety and Health Administration (OSHA) regulations; they need timely access to the right training, equipment, and technology; and they need to be compensated at a level commensurate with the intensity of the care they provide. These needs must be accompanied by a multi-faceted financing approach that involves securing and distributing federal emergency funding relief and longer-term appropriations, reforming Medicaid and Medicare reimbursement rates, and allocating wage pass-throughs. Employing effective processes requires that oversight bodies at federal and SLTT levels deliver clear, concise, timely, transparent, and evidence-based guidance and instruction for compliance, as well as streamline reporting requirements. Moreover, nursing home owners and administrators, along with their oversight bodies, share responsibility for ensuring that required processes for operation are implemented and continuously improved as new learnings emerge about the pandemic. As such, CMS actions in response to the pandemic should have the intention of increasing organizational capacity so that nursing home staff fulfill their responsibilities related to the care and protection of residents. Increasing organizational capacity can involve both effective oversight and enforcement but also leveraging the resources and insights gleaned from a national level perspective of the pandemic and disseminating them to others at the ground level."

In the wake of the COVID-19 pandemic, authors of a commentary call for nursing homes to match patients with appropriate care models, increase training and payment for staff, and investigate better financing models.

As Fulmer, et al. (2020) observe, "…there is agreement that, in general, America's nursing homes are not designed, operated, or funded to deal effectively with infectious disease epidemics, and their staff are often too few and inadequately paid, protected, and trained. While knowledge related to caring for residents during COVID-19 accrues, nursing homes will continue to apply multiple strategies to meet the many different requirements for care of their older residents… As the primary financiers for short- and long-term nursing home stays respectively, the payment rules of Medicare and Medicaid will play crucial roles in realizing a new vision for the appropriate services and settings for the care nursing homes currently provide."

The American Health Care Association (AHCA) and LeadingAge assert that as nursing homes emerge from the pandemic, lawmakers must commit to substantive reform and support for the industry, and earlier this year have proposed the Care For Our Seniors Act – a reform package that will support better pandemic management and strengthen overall care in nursing homes. The package consists of four policy areas:

- Clinical improvements to enhance quality of care: Enhance the quality of care in nursing homes by developing robust standards for infection preventionists, requiring that each nursing home have a registered nurse on-staff, 24 hours per day, and requiring a minimum 30-day supply of personal protective equipment in all nursing homes.
- Workforce improvements to strengthen and support our frontline caregivers: Strengthen and support our frontline caregivers by implementing a multi-phase tiered approach to attract, retain and develop more long-term care professionals leveraging federal, state and academic institutions.
- Oversight reforms to make systems more resident-driven: Establish a more resident-driven system that is focused on improvement to ensure nursing homes are compliant and providing high quality care. This would include implementing a process to help turn around or close facilities that are chronic poor performers and adding customer satisfaction to the government's five-star rating system to help guide potential residents and family members.
- Structural modernizations focused on resident dignity and safety: Modernize nursing homes by conducting a national study on how to shift to more private rooms, which promote resident privacy, autonomy and dignity, as well as support infection control best practices.

As AHCA/LeadingAge state, "Implementing these reforms requires a commitment from federal and state lawmakers to properly fund nursing homes – particularly ensuring that Medicaid reimbursement rates cover the actual cost of care. With most nursing homes already operating on razor-thin margins, the cost of making improvements will not be possible without financial assistance. Long-term care was forgotten at the beginning of the pandemic, but it cannot be forgotten now. Lawmakers have an opportunity to put America's seniors and frontline caregivers first."

Let us review each tenet of the Care For Our Seniors Act, as it establishes a comprehensive blueprint for improvements in long-term care.

1. Quality of Care

The first component is an enhanced infection preventionist. As we know, effective infection prevention and control programs can decrease infection rates and HAIs, improve attention to hand hygiene and transmission-based precautions, improve employee health, and reduce hospitalizations and adverse events among nursing home residents. As AHCA/LeadingAge explain, "While some facilities have designated one or more part-time, specially trained IPs, others have fulltime IPs, or have IPs fulfill a broader role, with duties such as staff educator or supervisor. Prior to COVID-19, nursing homes already experienced a nationwide shortage of RNs and other challenges in recruiting qualified staff, including IPs. The pandemic has only exacerbated these workforce challenges. The

increased demand for resources and dedicated, specially trained IPs, which are most often fulfilled by a RN, have critically strained nursing homes… The COVID-19 pandemic requires us to reflect upon whether the current regulation is adequate to ensure staff with expertise in infection prevention and control are effectively used in nursing homes."

The proposed solution, according to AHCA/LeadingAge, is to create an evidence-based standard for staffing IPs in each nursing home where the amount of time required for an IP is correlated with meaningful environmental factors. Additionally, AHCA and LeadingAge recommend:

• The amount of time required for an IP is adjusted based on each facility's bed count, demographics of the facility's surrounding area, individual factors contributing to infection control risk levels, and corporate or other support resources.

• Flexibilities for smaller and rural facilities.

• A diverse group of professionals be allowed to serve as an IP with training as described in current regulation.

• A phased-in requirement to give nursing homes time to recruit and train without threat of penalty for noncompliance.

• The IP is recognized in the CMS Payroll-Based Journal as a role centered around resident care.

Implementation would include:

• Loan forgiveness for RNs in long-term care and to other professionals (such as those with a public health degree) who serve as IPs in nursing homes

• Offer grants to pay for initial and ongoing continuing education units/training for IPs

• Provide tax incentives or accreditation recognition for professional schools whose graduates work as an IP in nursing homes

• Require states to incentivize enhanced infection prevention through state quality payment programs

• Create national database of IPs for networking and recruiting

• Provide value-based purchasing incentive for nursing homes with a full-time IP on staff

• Ensure the Nurse Licensure Compact is available in every state to be able to share RNs across state borders

• "Train the Trainer" supports from state public health officials to help nursing home providers adapt to IP turnover or other emergent issues

It is proposed that these action steps would be funded by Medicaid payment policy.

The second component is a new federal requirement that each nursing home have a RN on-staff 24 hours a day.

Implementation would include:

• Policies increasing nurses in nursing homes also need to incorporate strategies to attract more nurses to work in long term care. Prior to implementation of such a requirement, several steps are needed to achieve RNs being available 24 hours a day in nursing homes, including financial incentives to RNs and students in RN training, as well as to schools/universities and nursing homes.

• National campaign to recruit RNs into nursing homes, including showing the value of nursing homes and calling to serve LTC populations, as well as highlighting the incentives available to RNs who pursue careers in nursing homes available to new graduates as well as experienced RNs

• Level the playing field for RNs in nursing homes by aligning reporting of nurses to their licensing board for adverse events to be consistent in all settings.

• Support state-based efforts such as creating and funding an emergency workforce, available from local and state sources, to deploy to nursing homes in need to maintain requirements.

It is proposed that these action steps would be funded by Medicaid payment policy and Medicare rates.

The third component is adequate ***personal protective equipment (PPE)***, which, as we know, improves infection control outcomes and has the potential to reduce mortality rates associated with infection outbreaks.

The proposed solution is to require every nursing home to have a minimum 30-day supply of PPE for average conventional use. Nursing homes may also employ conservation strategies, if needed, to extend use of PPE – an effort that must be supported by ongoing federal and state stockpiles of PPE that is in acceptable condition for healthcare use. This 30-day minimum supply includes gloves, gowns, goggles/face shields, facemasks and N-95 masks, as well as alcohol-based handrubs and disinfecting supplies.

Implementation would include:

• The federal government must prioritize nursing homes for allocation of PPE.

• Allow adequate timeline to secure necessary PPE for initial minimum supply.

• Offer waivers to facilities when supply is not available outside of facility control, such as notifying state or federal agency when PPE supply is below 30 days and not able to replenish.

• Federal and state governments provide credible PPE wholesale supplier registries that are made available to the public. Providers need access in order to meet any PPE stockpile requirement.

• Through registries, federal and state agencies monitor for price gouging of required PPE and disinfection supplies.

• Maintain national and state stockpiles for additional support and established direct pathway for nursing home providers to request and receive timely supplies.

It is proposed that these action steps would be funded by federal and state governments.

2. Workforce: Strengthen and Support Frontline Caregivers

Workforce recruitment and retention is one of the most pressing challenges confronting long-term care facilities. As AHCA/LeadingAge observe, "Long-term care was already dealing with a workforce shortage prior to COVID, and the pandemic exacerbated the crisis as staff members got sick, had to isolate, or lacked childcare options. At the same time, already thinly stretched staff members had to do more than ever before, as residents required additional one-on-one care to help prevent spread of the virus as well as fill the void of loved ones who could not visit in-person."

The multi-phased approach includes incentives necessary to attract, keep, and develop long-term care staff by leveraging federal, state, and academic resources—a key first step to increase workforce availability, AHCA/LeadingAge emphasize. Strategies address challenges including financial assistance for potential and current caregivers, training, educational opportunities to develop their skills, and streamlined pathways for professionals to build a career in long-term care.

Financial assistance components include providing student loan forgiveness for licensed healthcare professionals who are new graduates and work in long-term care, as well as providing tax credits for licensed healthcare professionals who work in LTC facilities.

Regulatory solutions include:

- Create a pathway (including training and testing) for temporary nurse aides allowed by the current Public Health Emergency (1135 waiver) to become nurse aides
- Review state policies to reduce burdensome regulations and streamline opportunities to enhance the long-term care workforce (such as providing facilities the flexibility to run their own CNA training programs)
- End ban on CNA training programs after a nursing home receives a civil monetary penalty (CMP) or substandard quality of care deficiency, or, at minimum, allow facilities to restart their training program when they demonstrate that they are back in compliance. Currently, nursing homes with these citations face a two-year ban on being able to train CNAs.
- Ensure the Nurse Licensure Compact is available in every state to be able to "share" RNs across state borders
- Expedite the progression in licensed practical nurse (LPN) to RN bridge programs to increase the number of RNs
- For professional licensing boards, change the reporting for adverse events that can trigger, licensure sanctions, personal CMPs and criminal actions, which is a known barrier to recruitment and retention. These changes would not apply to rare events that are egregious or criminal in nature.

It is proposed that these action steps would be funded by federal and state governments.

3. Oversight: Improving Systems to be More Resident-Driven

As we know, the purpose behind government oversight of nursing homes is to ensure the safety and wellbeing of residents; AHCA/LeadingAge assert that "…the current survey and enforcement system treats nursing homes like they are all bad actors, and as a result, the system has been shown to be inconsistent and ineffective. The current process does not drive improved quality of care and quality of life for nursing home residents. The same modes of citation and penalty have been used for decades and have not evolved to reflect the science of quality improvement nor a current understanding of how to effectively use oversight to create change and achieve desired outcomes. Nursing homes, consumer advocates, Congress, and the Centers for Medicare and Medicaid Services (CMS) are dissatisfied with both the process and results. The extensive investment of time and funding in the inspection process by state survey agencies, the federal government, nursing home staff, and other stakeholders is not delivering an equal or better return on investment to benefit the residents the system is intended to serve."

Last year, the National Academies of Sciences, Engineering, and Medicine recognized this suboptimal system and launched a study to revisit the connections between the regulations/survey process and quality.

As AHCA/LeadingAge state, "The punitive nature of the process drives qualified staff out of long-term care and into other healthcare jobs where the oversight process focuses on supporting a culture of safety and continuous quality improvement. Moreover, excessive fines take away precious resources needed by facilities to make necessary improvements for better resident care. In addition, CMS spends a substantial portion of its survey budget on addressing poor-performing nursing homes, yet the current process and use of resources is not improving resident care among struggling providers. We must foster an approach where providers and regulators have a shared responsibility to do what is best for the residents, recognize good faith efforts, and effectively remedy identified issues."

AHCA/LeadingAge recommend a three-tiered approach that leverages continuous learning to improve the oversight and enforcement process for better resident care:

1. Incorporate a good-faith effort evaluation and quality improvement focus on the survey process.
2. Understand when and how citation and enforcement remedies are helpful in driving compliance and improvement and apply consistently across the U.S.
3. Align state survey agency performance evaluation with the CMS mission of assuring basic levels of quality and safety for all residents.

It is proposed that these action steps would be funded by current CMS and state survey agency funding, which is a budget-neutral proposition.

4. Structural: Modernize for Resident Dignity and Safety

Capital improvements to nursing homes have been delayed due to chronic Medicaid underfunding, which also makes the goal of private rooms largely unattainable. As AHCA/LeadingAge explain, "The current reimbursement system incentivizes providers to put multiple long-stay residents and/or short-stay patients in the same room in order to make ends meet. Residents deserve better, and nursing homes must continue to evolve. These traditional care models for long-stay residents are no longer considered appropriate as a new, welcomed emphasis on person-centered care continues to emerge. One central aspect of this shift is a greater emphasis on residents' autonomy, dignity, and privacy. Increased privacy can also enhance the quality of care delivered, especially considering COVID-19 best practices and the efforts to promote infection prevention and control. To date, there has not been an organized examination of the broad range of factors related to different room configurations. Furthermore, there are no data sources on the number of buildings and rooms with more than two residents and no consistent approach to assessing the costs associated with a move to private and semiprivate rooms. Most research in nursing homes on this topic relates to psychosocial outcomes such as preference and satisfaction."

The proposed solution is to develop a national study that would provide evidence-based data on shifting to more private rooms in nursing homes, especially considering emerging infectious threats. The national study would be framed by two key guiding principles: assess nursing home design to address the COVID-19 pandemic and improve infection control; and modernize to meet market preferences. As AHCA/LeadingAge note, "It is vital to understand the role private and semi-private

rooms play in infection control strategies, as well as the costs and strategies needed to redesign nursing homes to prevent and contain COVID and other novel infectious diseases."

It is proposed that these action steps would be funded by Medicaid payment policy.

The Care For Our Seniors Act represents meaningful change that requires significant funding. As AHCA/LeadingAge emphasize, "Real, long-lasting transformation that will truly protect residents requires a considerable investment in the LTC profession. Long-term care providers stand ready to make meaningful change that can help our residents, our staff and our country. But it won't be possible without a commitment from policymakers to provide the necessary and consistent financial support for our elderly residents. For too long, nursing homes have faced chronic Medicaid underfunding and unfunded government mandates, leaving many unable to afford enhancements in their care delivery, workforce and infrastructure. COVID-19 has exacerbated these economic challenges. Nursing homes have spent tens of billions responding to the pandemic specifically PPE, testing, additional staff and bonus pay. Coupled with significant losses due to fewer new residents, the nursing home industry expects to lose $94 billion over the course of the pandemic (2020-2021). As a healthcare provider that relies almost entirely on government reimbursement (Medicare and Medicaid), nursing homes cannot make substantial reforms on their own. They need the support of federal and state policymakers and resources."

AHCA and LeadingAge have developed four interrelated, investment strategies that will help ensure a robust and quality long-term care system:

- Enhanced Federal Medical Assistance Percentages (EFMAP): Increased federal Medicaid funds are provided to states to pay for the mandatory nursing facility benefit, with requirements that additional federal funds be used for nursing facility rates.
- Federal framework for "allowable cost" or "reasonable cost": Establish federal guidelines for state allowable cost definitions.
- Medicaid rate adequacy requirement: Medicaid rates are brought up to equal the cost of care and subsequently updated regularly to keep pace with increases in costs of care.
- State nursing facility Value-Based Purchasing (VBP) committee and required design report: The state will be required to form and maintain a state, health plan, and nursing facility VBP committee with specific guidelines and deadlines to submit reports. This offers the potential for additional resources.

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