

Geography Is Not Destiny: Protecting Nursing Home Residents from the Next Pandemic



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Methodology: The evaluation and recommendations in this report were derived through a combination of original quantitative analysis of the Centers for Medicare & Medicaid Services’ (CMS) COVID-19 Nursing Home Dataset and Care Compare Database, along with a qualitative review and examination of existing published research and articles, legislation, and legislative actions. Findings were supplemented by select firsthand interviews with nursing home administrators in three areas around the nation – Los Angeles County, CA; Maricopa County, AZ; and Hartford County, CT. Administrators in each of these counties represented one high-performing and one low-performing nursing facility, as defined as falling into either the lowest (for high-performing) and highest (for low-performing) percentile of average percentage of COVID-19 infections per total facility residents.

EXECUTIVE SUMMARY

On January 21, 2020, the Centers for Disease Control and Prevention (CDC) confirmed the first case of the 2019 novel coronavirus (COVID-19, or COVID) in the United States.¹ Since then, COVID-19 has swept across the country at a fast and furious pace. Over 27 million Americans have been infected, and it has claimed the lives of over 475,000. Though vaccine relief is on the way, until distribution problems can be remedied, COVID’s devastation will only continue to grow.² Older adults and those in nursing homes have been hardest hit. According to the CDC, eight out of 10 COVID-related deaths have occurred in those aged 65 years and older.³ Furthermore, despite the fact that only five percent of this country’s COVID cases have happened in long-term care facilities, as of mid-February 2021, more than 166,000 long-term care^a residents and staff have succumbed to their infections⁴ – amounting to about 36 percent of the national death toll at time of calculation.

With these staggering statistics, the question remains: *How many deaths could have been avoided, and how many lives can be saved moving forward?*

“It went off like a bomb. It was bad. Really bad. We saw a lot of patients die. We had a lot of staff that tested positive and got sick. When it went off, it went off hard.”

– Nursing Home Administrator, Los Angeles County, CA

What we do know is that these deaths were not inevitable. COVID-19 exploited and exacerbated long-standing issues that existed for decades in the long-term care industry – staff shortages, poor work environments, direct care workers not getting enough pay, training, or solid career prospects, and challenges with basic infection control precautions, to name a few. The wrath of COVID-19 in our nursing homes was felt, in large part, because we, as a nation, have not prioritized fixing long-standing issues such as these.

“COVID caught us with our pants down.”

– Nursing Home Administrator,
Maricopa County, AZ

We know more now. The lessons are clear. It’s time to act. COVID-19 very likely will not be the last pandemic we experience in our lifetimes,⁵ and if we don’t address these issues now, we will see these mass casualties again. If we miss this opportunity for change, we will be to blame when the next disaster strikes – and when avoidable harm occurs during “normal” times.

While broad strokes are needed to make sweeping changes, smaller repairs are also required to fill the cracks in the nursing home industry’s foundation. That involves fine-tuning and strengthening existing laws, where the minute details matter. We must dig beyond the surface for solutions. For example, it’s not just that we need to enforce the current regulation that nursing assistants complete 75 hours of training to become certified nursing assistants. If you look a little more closely, you’ll see that this law stipulates that 16 hours of that training must come in the form of supervised hands-on experience. Evidence demonstrates that such supervised practical

^a “Long-term care facilities” in this case includes all types of senior housing and care facilities – nursing homes, assisted living, and skilled nursing facilities.

training leads to better health outcomes for residents. It's time we returned to nursing home policymaking that rests upon evidence-based solutions – like targeting those practical training hours specifically – to ensure that those tasked with caring for our nation's elders are well-equipped to do so.

The provisions laid out in the 1987 Nursing Home Reform Act were a fundamentally important step in securing the safety of our nation's older adult population, and they have created a framework that has persisted through this day in setting and enforcing standards of care that have undoubtedly improved countless lives. The Obama Administration's 2016 revisions were also important, but COVID-19 has pushed us all into a new era. As a nation, we have never in recent history faced a health threat as strong and shift as this coronavirus. The same is not true everywhere in the world, however. Many nations that have faced pandemics in the recent past have learned after each experience. We must as well, for the currency now is lives – lives lost or lives saved – and the choice is ours.

This report aims to accomplish the following:

1. Examine the belief that “geography is destiny” as the prevailing theory of nursing home COVID-19 transmission
2. Identify needed actions for nursing facilities to take, building from current evidence-based research and insights gained through interviews with nursing home administrators in counties with some of the highest reported prevalence of COVID-19 (as identified through CMS data)
3. Provide policy recommendations

As you read through the pages that follow, you will find that the question of “what went wrong” in our nation's nursing facilities over the course of this COVID-19 crisis opens areas of inquiry that span across frameworks of category, scale, and scope – from the highest-level decisions made by those in top government posts, to the minute individual choices and circumstances of nursing home residents and staff themselves. To help better comprehend and address these vast and expansive issues, we have divided our insights into three categories – People (the nursing home staff and leadership), Place (the effects of the physical environment), and Protocols (the laws, rules, provisions, and guidelines that provide the underlying regulatory and response structure by which nursing facilities must abide). Our high-level findings are summarized in Table 1, below.

Table 1: Summary of Actions Needed and Policy Recommendations

Actions Needed	Policy Recommendations
PEOPLE – Staffing	
<ol style="list-style-type: none"> 1. Increase registered nurse (RN) staffing and the overall total direct care staff 2. Treat direct care workers with respect by providing: <ul style="list-style-type: none"> – A living wage and good benefits – Quality training and a career ladder 	<ol style="list-style-type: none"> 1. Establish a federal minimum hours per resident per day for RNs and total nurse staffing 2. Increase the federal minimum hours of training required to become a certified nursing assistant (CNA) – increase supervised clinical training requirements within that total 3. Increase the hourly wage for direct care workers to a living wage in each state 4. Establish minimum direct care staff-to-patient ratios
PEOPLE – Leadership	
<ol style="list-style-type: none"> 1. Build inclusive leadership skills 2. Think ahead, be flexible and self-aware 	<ol style="list-style-type: none"> 1. Establish a federal minimum competency standard for nursing home administrators to gain licensure
PLACE	
<ol style="list-style-type: none"> 1. Limit the number of residents per room 	<ol style="list-style-type: none"> 1. Revise current federal nursing home regulations that allow up to four residents per room – limit occupancy to two (2) residents per room
<ol style="list-style-type: none"> 2. Make it a <i>home</i> – Prioritize social connection and engagement of residents 	<ol style="list-style-type: none"> 1. Establish an “essential caregiver” for residents in federal law 2. Mandate the designation of a virtual visit coordinator
PROTOCOLS	
<ol style="list-style-type: none"> 1. Prioritize enforcement of infection control deficiencies 	<ol style="list-style-type: none"> 1. Re-strengthen the definition of immediate jeopardy 2. Roll back Trump Administration loosening of Civil Money Penalty (CMP) sub-regulations 3. Prioritize infection control deficiency oversight during and after the COVID-19 crisis
<ol style="list-style-type: none"> 2. Build up the infection prevention infrastructure and enforce pandemic preparation rules 	<ol style="list-style-type: none"> 1. Implement at least the CDC’s recommendation of one full-time sole-focused infection preventionist (IP) as the minimum federal standard 2. Review current emergency preparedness requirements to determine if changes are needed to ensure residents are protected; focus on enforcing these standards
<ol style="list-style-type: none"> 3. Better align federal and state coordination and communication around public health guidance 	<ol style="list-style-type: none"> 1. Study other nations’ centralized communication structures and include long-term care advocates in the governing body

SECTION 1: GEOGRAPHY IS NOT DESTINY

Before we embark upon our examination of the experiences of nursing homes across the country in their battle against COVID-19, we must first address one popular theory used to explain the vulnerability of these facilities to the novel coronavirus. This theory essentially boils down to the old adage that “geography is destiny,” which, in the case of COVID-19, means that the prevalence of the disease within a *community* will most likely lead to outbreaks *in nursing facilities in the area* due to factors such as the inevitable exposure of staff, who will ultimately carry infection in. University of Chicago’s Dr. Tamara Konetzka released a report in the *Journal of the American Geriatrics Society* in August, which concluded just this point. “Prevalence of COVID-19 in the community,” she wrote, “remains the strongest predictor of COVID-19 cases and deaths in nursing homes.”⁶ This argument, however, is certainly neither ironclad nor the entire story.

Though analysis of the CMS COVID-19 dataset (updated through December 27, 2020) and data from CMS’s Care Compare Database, the Center for Medicare Advocacy (CMA) has found correlations between controllable variables and the success with which a nursing home has kept COVID-19 out. These variables include ownership types, factors captured by CMS ratings, staffing, personal protective equipment (PPE), and the availability of resident/staff testing.

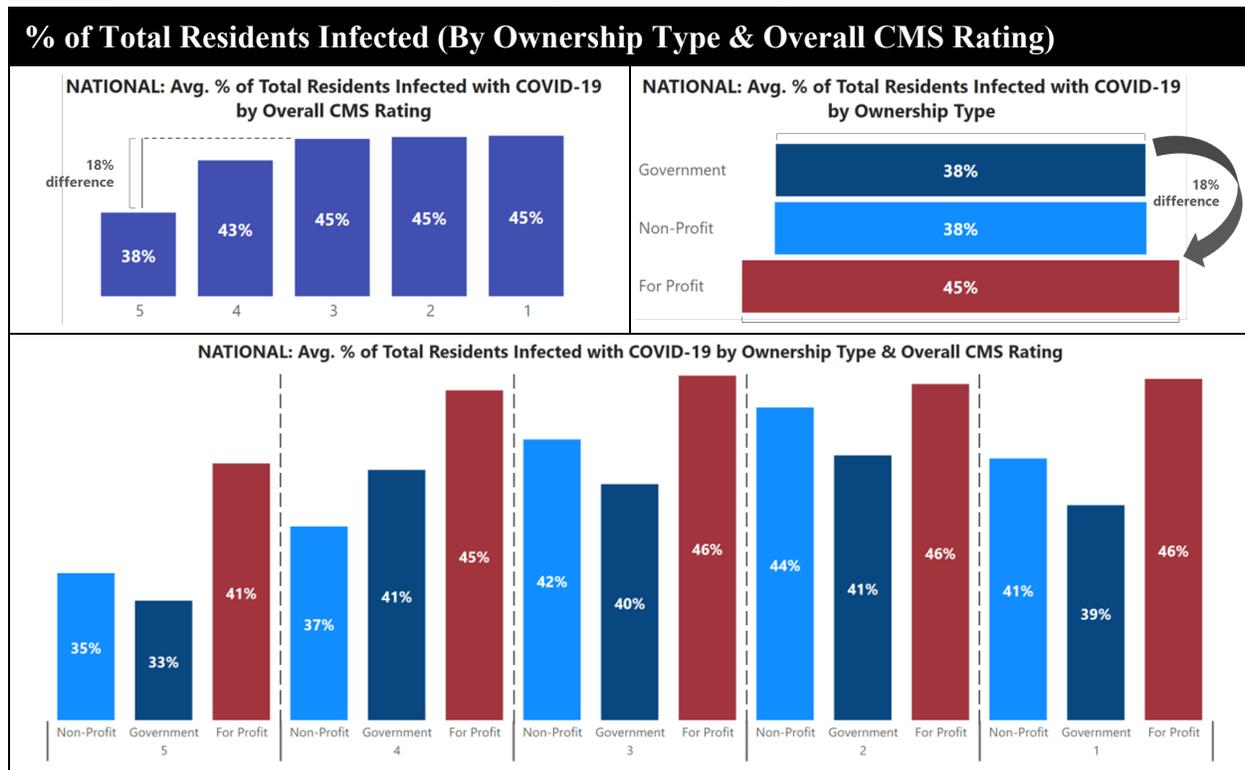
CMS Overall Star Ratings. As demonstrated in Table 2 below, looking at data that combines both CMS’s COVID-19 database and Care Compare, clear patterns emerge around the realms of ownership and CMS star ratings. In this case, facilities with CMS’s highest rating have been **18 percent more effective** at preventing COVID infections (seven percentage points lower) than the lowest rated one-, two-, and three-star facilities.

Ownership. Additionally, ownership structure appears to provide some predictive value for COVID-19 infection rates. Looking at the nursing home industry as a whole, facilities owned by for-profit entities have been **18 percent less effective** at preventing COVID-19 infections than facilities run by non-profit or government entities.

Combined. When joining the data and bucketing facilities by both CMS ratings and ownership type, we see an even more clear illustration of the parallel between ownership type and a facility’s ability to keep COVID-19 at bay. **For-profit facilities are the worst performers across every CMS rating pool.^b**

^b CMS’s Five-Star Quality Rating System gives each nursing home a rating of between one and five stars. The rating system is based on nursing home performance on health inspections, staffing, and quality measures. Each of these has its own rating, as well. Nursing homes with 5 stars are considered to have much above average quality rating and nursing homes with 1 star are considered to have quality much below average. (CMS, Design for *Nursing Homes Compare* Five-Star Quality Rating System: Technical Users’ Guide (Oct. 2020))

Table 2: Resident Infections vs. Ownership and CMS Rating

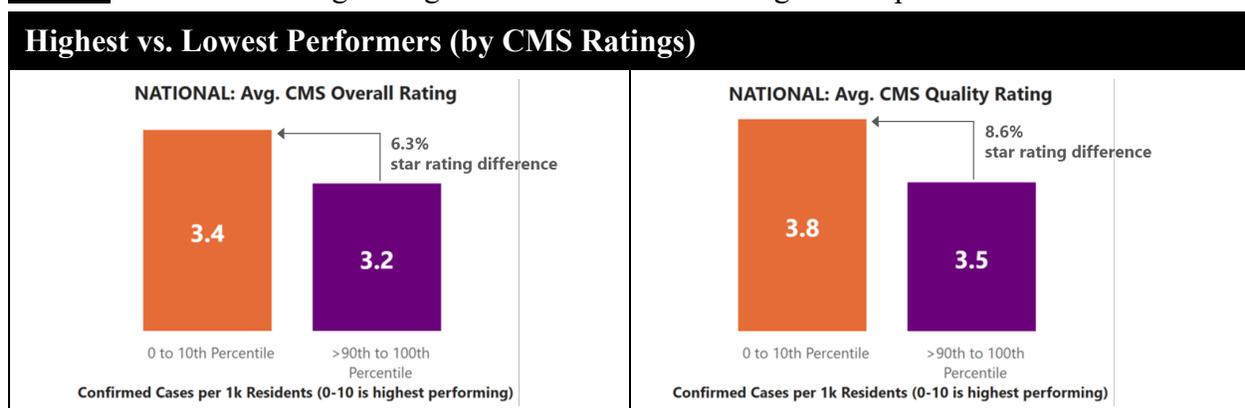


Sources: CMS COVID-19 Dataset (data through 12.27.20) and CMS Care Compare Database

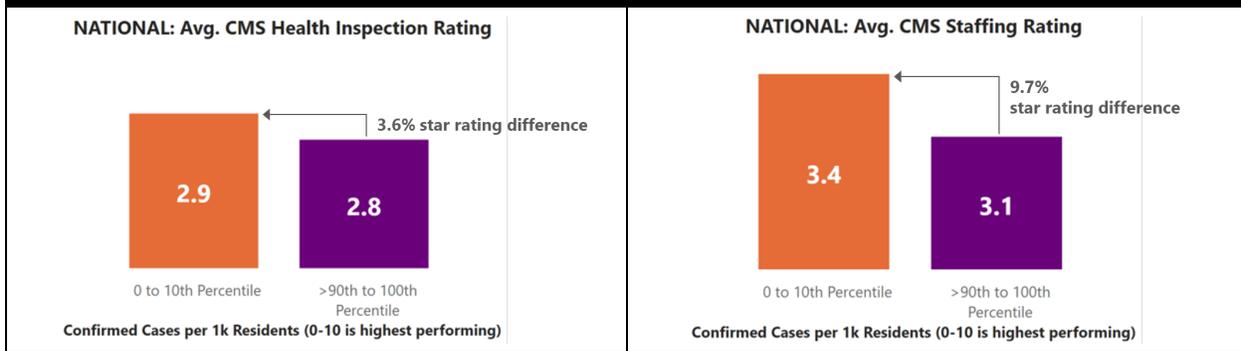
Note: COVID-19 Dataset cleaned to exclude facilities that failed quality assurance check or that reported more cases than residents

CMS Star Rating Components. Breaking down CMS ratings into their component parts and comparing data for nursing homes that have been the most successful in keeping COVID-19 out (i.e. were in the bottom percentile for reported number of infections per 1,000 residents) with those that performed most poorly (i.e. were in the top percentile for reported number of infections per 1,000 residents), we can see that across each element of the overall star rating, the same pattern emerges. Nursing homes in the highest performing grouping received a: **6.3% higher overall star rating** (3.4 vs. 3.2), an **8.6% higher quality rating** (3.8 vs. 3.5), a **3.6% higher health inspection score** (2.9 vs. 2.8), and a **9.7% higher staffing rating** (3.4 vs. 3.1).

Table 3: CMS Star Ratings – Highest vs. Lowest Performing “Cases per 1k” Percentiles



Highest vs. Lowest Performers (by CMS Ratings)



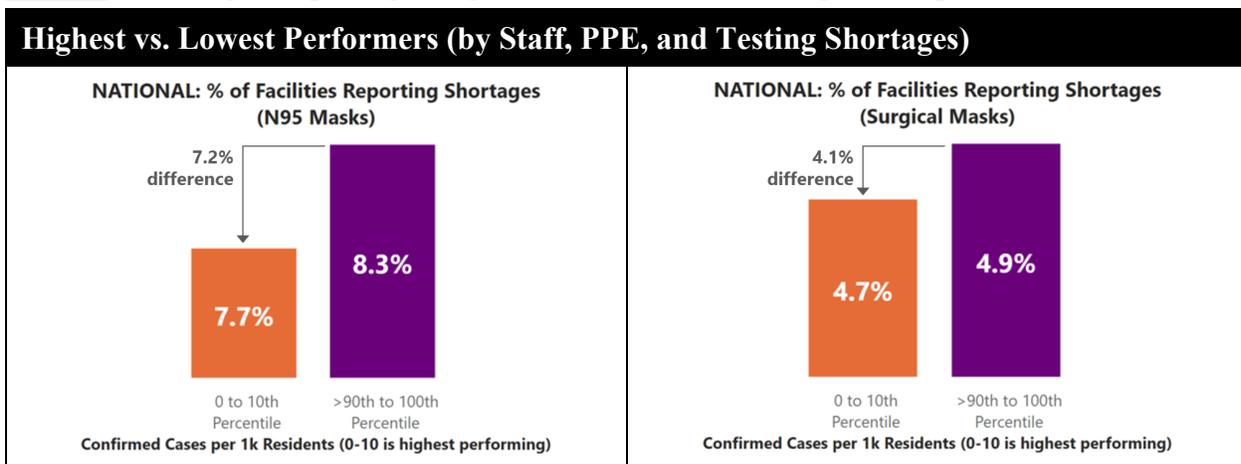
Sources: CMS COVID-19 Dataset (data through 12.27.20) and CMS Care Compare Database

Note 1: 0-10th Percentile avg % of total residents infected = 2.8% (n=1,181 facilities); >90th to 100th Percentile avg. % of total residents infected = 94.3% (n=954 facilities)

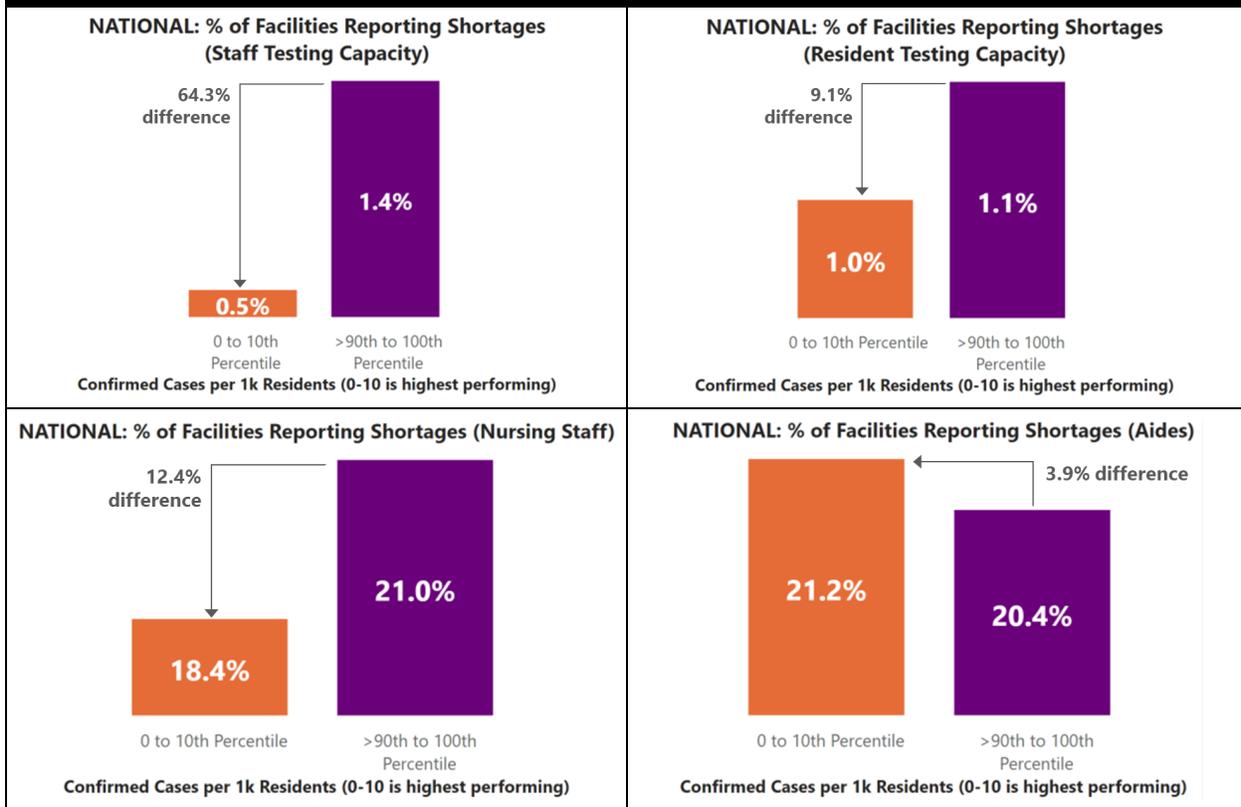
Note 2: COVID-19 Dataset cleaned to exclude facilities that failed quality assurance check or who reported more cases than residents

“Shortage” Reporting. Finally, examining nursing homes’ self-determined “shortage” reporting, we can see that **higher performing facilities are generally better prepared** in terms of access to PPE (i.e. less than one-week supply), testing capacity (i.e. ability to test all staff and residents within one week), and nursing staff (i.e. whether they report a “shortage”). Interestingly, however, there is a reverse correlation between reports of nurse aide shortages and facility performance. While there are multiple potential explanations for this apparent aberration in the data, this data point may also further validate one strong study that we will discuss shortly, which demonstrated a positive correlation between RN staff hours and infection performance. The fact that fewer high-performing facilities report shortage in nursing staff could be an additional indication of the essential role that these skilled providers play in fighting off COVID-19.

Table 4: “Shortage” Reporting – Highest vs. Lowest Performing “Cases per 1k” Percentiles



Highest vs. Lowest Performers (by Staff, PPE, and Testing Shortages)



Source: CMS COVID-19 Dataset (data through 12.27.20)

Note 1: 0-10th Percentile avg % of total residents infected = 2.8% (n=1,181 facilities); >90th to 100th Percentile avg. % of total residents infected = 94.3% (n=954 facilities)

Note 2: COVID-19 Dataset cleaned to exclude facilities that failed quality assurance check or who reported more cases than residents

Though the level of infection found in the surrounding community does undoubtedly create additional challenges for nursing homes battling to keep COVID-19 at bay, as this data makes clear, a facility’s location does not equate to a facility’s fate. There are measures that can be taken to protect vulnerable residents and staff. As we investigate further, we will begin to see other patterns emerging – insights that help us begin to sketch out the dividing lines, the markers, hills, and turns of the path to protection that our nation’s nursing homes so desperately need.

SECTION 2: ACTIONS NEEDED – PEOPLE

Some of the most harrowing stories to come out of this crisis over the past year have been about those who are on the front lines in nursing facilities across the country. Nurses, administrators, and direct care workers have been putting themselves in harm’s way to provide needed everyday services for the older adults under their care, all while facing unprecedented hazards and trying to keep a deadly infection at bay for themselves and their residents. None of this would have been easy – even had they been prepared for such an emergency with a strong foundation. What has become unfortunately evident, however, is that this pandemic has struck hardest in places where no such solid ground existed. Nursing facilities have largely been operating with lower levels of staff support than they should have been. Their direct care workers have not been provided the living wages that they would need in order to remain focused on the crisis at hand, and training has been insufficient to prepare them for the daily hardships they’re facing.

Leadership has had to carve their own paths through uncharted territories, and those who are tasked to lead have not always been adequately prepared to do so. COVID-19 struck an industry that was already suffering from cracks in its personnel foundations – cracks which led to vastly different responses from different facilities, resulting in varying levels of success in being able to battle this deadly disease. The positive news is that we now have a better idea of what it means to be prepared – and just how much that preparation can matter when it comes to protecting nursing home residents’ lives. Our actions needed based on lessons learned about the role of “people” in fighting off COVID-19 can be broken into two categories – staffing and leadership. Following are some of the insights that have emerged.

PEOPLE – STAFFING

“I didn’t hire any new staff per say. I just reallocated my resources. We were understaffed because a lot of our staff members got COVID. Our rehab therapists did some CNA work. At the end of the day, our team came together. Whether it was the therapists, or the activities department or our HR people. They just got suited up and they helped our patients the best way they knew how.”

– Nursing Home Administrator,
LA County, CA

vs.

“We’ve continued to hire throughout the pandemic. It’s hard to get staff. It’s been tough. We’ve had to do sign-on bonuses, increase wages, really ‘sell’ the facility. We’ve hired full-fledged CNAs that are licensed. We haven’t done the temporary [nurse] aides.”

– Nursing Home Administrator,
LA County, CA

The heart and soul of any nursing facility is the staff that dedicate their working lives to the residents under their care. If nursing homes are to be prepared to handle a ravaging infectious disease like COVID, all roads must run through these hard-working nurses and direct care workers. So what have we learned about what works and what’s missing from the nursing facility staffing model in place today? Perhaps the most important lesson to come out of this crisis is that real benefit – measurable in lives saved – can be realized by ensuring that nursing

facilities have the right numbers and the right mix of nursing and direct care workers on hand. Addressing staffing levels means more time dedicated to each resident’s care, and lower risk of staff distraction and burnout, leading to higher quality care. Of course, achieving such an improved state is not entirely straightforward. Systemic issues must first be addressed – related to the efficacy of existing regulations, access to a stable supply of direct care workers who are incentivized to stay and grow in the industry, and perceptions around the cost-benefit trade-offs of increasing staff pay and training budgets.

Action Needed #1: Increase registered nurse (RN) staffing and the overall total direct care staff.

Staffing matters. Higher RN staffing levels are not only associated with better quality of care for residents, but research suggests that inadequate staffing levels negatively affect the quality of care that residents receive. Charlene Harrington, from the University of California at San Francisco, published a study based on a survey of RNs working in nursing homes during the pandemic, finding “that 72 percent of the nurses reported missing one or more necessary care tasks on their last shift due to lack of time or resources.”⁸

According to federal staffing requirements established by the Nursing Home Reform Act (NHRA) of 1987, nursing facilities that receive Medicaid and Medicare payments must provide nursing services to meet the care of their residents. Each facility is required to have an RN on duty at least 8 consecutive hours a day, every day of the week. Licensed nurses (such as licensed practical nurses (LPNs), or licensed vocational nurses (LVNs) must be on duty 24 hours a day, and a full-time designated RN must serve as director of nursing.⁹

The Importance of Staffing

A recent *JAMA* study examined COVID-19 data from eight state health departments: California, Connecticut, Florida, Illinois, Maryland, Massachusetts, New Jersey, and Pennsylvania. These states were chosen because they ranked among those with the highest COVID-19 burden. Looking at the three CMS quality score domains (health inspection, quality measures, and nurse staffing) the authors assessed the likelihood of high-performing facilities (4- or 5-star ratings) to have COVID compared to facilities that were relatively low-performing (1- to 3- star ratings). Across all eight states, the study found that high-performing staff rating nursing homes had fewer COVID cases than nursing homes that performed poorly in staffing. The researchers concluded that nursing homes with staff shortages may increase susceptibility to the spread of COVID-19, and that “although guidance on best practices on infection control are important, which has been the primary strategy used by CMS to date, policies that provide immediate staffing support may be more effective at mitigating the spread of COVID-19.”⁷

The Centers for Medicare & Medicaid Services’ (CMS) ratings for staff are based upon two measures: (1) RN hours per resident per day (HPRD^c) and (2) total nurse staffing (the sum of RN, LPN, and nurse aide) HPRD.¹⁰

^c Nurse staffing hours are reported through the Payroll-Based Journal (PBJ) system on a quarterly basis. The reported nurse staffing hours per resident per day are calculated by dividing the sum of the reported hours by the sum of the resident population.

Harrington’s report highlights that in 2001, a CMS study identified minimum staffing levels that prevented harm and jeopardy to residents. For long-stay residents, the recommended minimum staffing levels for RNs should be 0.75 RN HPRD and a total of 4.1 nursing HPRD. A majority of states have established their own minimum staffing requirements and there is a wide range of staffing levels in nursing homes throughout the country.¹¹ In a separate report, Harrington points out that California established its own minimum staffing requirements for nursing homes, requiring facilities to provide at least 3.5 HPRD. This staffing level is “well below the levels recommended by researchers and experts to meet the needs of each resident.” Harrington’s analysis led to the conclusion that California nursing homes with “low RN and total staff levels appear to have left residents vulnerable to COVID-19 infections.”¹²

This knowledge about the importance of nursing staff existed before COVID-19. RNs lead almost all aspects of care delivery in nursing homes, along with supervision of other nursing staff. University of Rochester researcher Yue Li recommended that while staffing requirements may be harder to raise nationally, nursing homes able to increase their RN hours should do so for more effective control of COVID-19 outbreaks. Li concluded that nursing homes with higher RN staffing and quality ratings have the potential to better control the spread of COVID and reduce deaths.¹³ Upon analyzing publicly available COVID-19 data in Connecticut, Li found that among facilities with one confirmed positive case, every additional 20-minute increase in RN staffing per resident per day was associated with a 22 percent reduction in confirmed COVID-19 cases, and a 26 percent reduction in COVID-19 deaths.¹⁴

Action Needed #2: Treat direct care workers with respect – provide a living wage and good benefits.

The U.S. Bureau of Labor Statistics classifies direct care workers into three main categories: Nursing Assistants (known as Certified Nursing Assistants or CNAs), Home Health Aides, and Personal Care Aides.¹⁵ The direct care workforce is comprised of about 4.5 million workers, including about 580,000 nursing assistants in nursing homes.¹⁶ As discussed earlier, part of CMS’s staff star rating is based on total nurse staff (the sum of RN, LPN, and CNA) HPRD.

The job of these direct care workers is not easy. CNAs, for instance, help residents with activities of daily living (ADLs) such as eating, dressing, bathing, and toileting.¹⁷ The work is physically and emotionally demanding, the pay is poor, benefits are marginal, and there are limited opportunities to climb the career ladder.¹⁸ The COVID-19 pandemic has only exacerbated this existing divide between value, difficulty, and recognition. According to Harvard University’s David Grabowski, nursing home workers “now have the most dangerous jobs in America.”¹⁹

“When COVID hit, it was a mass hysteria. If [staff] found out that we had COVID, they would either resign or they got COVID themselves and they didn't want to come back to work.”

– Nursing Home Administrator,
LA County, CA

As the baby boomer population ages, the demand for direct care workers is also growing. Starting in 2030 – in less than a decade – all boomers will be older than 65, and this segment will make up 21 percent of the national population. By 2060, nearly one in four Americans will be 65 or older, and the number of people who are 85-plus will triple.²⁰ These statistics have real-world

implications for the long-term care field. When a person turns 65, there is a 70 percent chance that the individual will require some form of long-term care services and supports (LTSS) in their remaining years.²¹ Direct care workers will be providing much of that care.

While the demand for direct care workers is growing, the long-term care industry is challenged to find enough people to fill the jobs, and to keep them once they do. More long-term care workers are leaving the sector than entering. Additionally, one in two direct workers will leave the job within the first year.²² The reasons for exiting the long-term care workforce include: poor supervision, meager benefits, high workloads, and few opportunities to move up the career ladder.²³ Any benefits that a facility might offer to these staff may also be used as a point of leverage, instead of as a true benefit. A Manatt study assessing New Jersey found that “some facilities pay higher wages in lieu of benefit packages; some facilities pay lower wages with benefits.” The firm’s report also highlighted that, in New Jersey, 13 percent of workers have no health insurance.²⁴

High turnover is a decades long issue that is yet to be resolved. Robert Butler, considered to be the founding father of modern geriatrics and creator of the National Institute on Aging at the National Institutes of Health, mused in his 1975 book *Why Survive? Being Old in America*, “One wonders why nursing-home administrators are surprised at the high turnover among their employees when it seems obvious that staff are looking for higher pay and less difficult employment.”²⁵

Poor pay has consistently plagued the direct care sector, leaving workers struggling to make ends meet. PHI, an organization that focuses on issues around the direct care workforce,^d has found that 13 percent of the nursing home direct care workforce lives in poverty, and due to these high rates of poverty and low earnings, 36 percent of these workers require some form of means-tested public assistance (including Medicaid, food and nutrition assistances, and cash assistance).²⁶ An examination of the median hourly wages of direct care workers in nursing homes shows that over the 10 years between 2009 and 2019, these essential staff received merely a 51 cent median hourly pay increase (\$13.39 to \$13.90 per hour).²⁷

A recent study showed that nurse aides held second jobs at a 35 percent higher rate than other workers, citing both poor wages and insufficient numbers of hours available in the primary job as factors.²⁸ Given the risk of moving between different long-term care facilities, holding multiple jobs could be a factor contributing to the spread of COVID-19 in nursing homes – directly impacting the safety of staff and residents.

It didn’t take a pandemic for the work at nursing homes to become dangerous for direct care workers, however. A report published in *The Journal of Nursing Home Research* highlighted that in 2012, “nursing homes were considered the most dangerous workplaces in the United States” and that they had “one of the highest occupational illness and injury rates (higher than coal mines, steel and paper mills, warehouse and trucking jobs).”²⁹ In a National Nursing Assistant Survey published in *The Gerontologist*, CNAs reported work-related injuries that included scratches, cuts, back injuries, muscle strains, black eyes or other bruising, and human bites.³⁰

^d PHI was formerly named “Paraprofessional Healthcare Institute” but modified its name in 2016 due to its view that “paraprofessional” is an outdated term for the direct care sector.

Additionally, because of the physical demands of the job (e.g., repetitive lifting, overexertion, or patient-inflicted injury), direct care workers in nursing homes are three times more likely to be injured on the job than the typical worker in the US.³¹

Increasing pay is an important first step to improving direct workers' unenviable working conditions – perhaps enabled by the presence of a health care worker union (see call-out box below). According to a report by *LeadingAge*, an organization representing non-profit nursing homes and senior care providers, paying direct care workers a living wage would solve many of the issues presented above. It would: reduce staff shortages, reduce turnover rates, boost productivity, and improve quality of care.

A living wage is one that would enable a full-time worker to pay for basic housing, food, transportation, and health care needs out of her own earnings, without needing to rely on public assistance.³³ According to MIT's Living Wage Calculator, the living wage in the U.S. in 2019 was \$16.54 per hour.³⁴ Direct care workers in nursing homes would need to make an additional \$2.64 per hour to reach this mark (a 19 percent hourly rate increase).

If wages were increased to the level of a living wage by 2022, this report estimates that 75 percent of direct care workers would be positively impacted. *LeadingAge* has assessed that the cost to enact this increase in 2022 would be \$9.4 billion. In 2016, total spending for the direct care field was \$366 billion, meaning a 2022 living wage increase would amount to about a 2.5 percent increase in total direct care wage spending.

A Role for Unions

A study published in *Health Affairs* linked the presence of health care worker unions in New York state nursing facilities with a reduction of COVID-related death rates. Those facilities with health care worker unions were associated with a “30 percent relative decrease in the COVID-19 mortality rate” and a 42 percent relative decrease in infection rates compared to facilities without these unions (even though counties with unions had higher infection rates than counties without). Unions were additionally associated with greater access to PPE – approximately a 14 percent increase in access to N95 masks and a 7 percent increase in access to eye shields. This may be one factor leading to the reduction of mortality rates.³²

Citing a recent study by economist Krista Ruffini, *LeadingAge* suggests that the cost savings stemming from improvements in “quality care may, alone, be enough to pay for the wage increases.”³⁵ Ruffini's study argues that when direct care workers in nursing homes are paid more, their performance will improve due to the positive psychological effects associated with lower financial burden and reduced cognitive loads. Her research indicates that a 10 percent increase in minimum wage overall would result in positive correlation in direct care worker pay specifically, and would lead to the prevention of thousands of deaths, fewer inspection violations, better patient outcomes, and reduced cost of care for preventable issues.³⁶

Preventing deaths: Extrapolating what Ruffini's research estimates would be a three percent reduction in nursing home deaths given a 10 percent overall minimum wage increase, she suggests that approximately 15,200 to 16,200 deaths would have been prevented (based on 2013 levels of nursing home deaths and controlling for resident demographics).³⁷

Lowering infractions and reducing preventable costs: Five infractions related to direct care staff performance account for about a quarter of all inspection violation citations – improper infection prevention and control, inaccurate medication records, unsafe or unsanitary food preparation and storage, not taking measures to avoid preventable accidents, and not providing enough basic care.³⁸ According to the Ruffini study, while a 10 percent increase in minimum wage overall does not significantly affect the likelihood that a nursing facility has any violation, it does appear to reduce the number of violations incurred by about one percent. It also appears to reduce the number of quality of care violations by two percent.³⁹ Nursing home residents would stand to benefit from such reductions in violations by avoiding otherwise preventable negative health impacts, while the facilities themselves would financially benefit by reducing their regulatory fines.

Finally, paying higher wages will decrease turnover, leading to lower training costs associated with hiring new staff.⁴⁰ According to PHI, conservative estimates of nursing assistant turnover across the long-term care sector range from 45-66 percent, and one in four nursing assistants is actively looking for a job.⁴¹ High turnover rates are costly for the nursing facility. A report by Linda Barbarotta for the Institute for the Future of Aging Services at the American Association of Homes and Services for the Aging (now known as Leading Age) estimates that the average direct and indirect (such as lost productivity until a replacement is trained) cost is \$3,500 per direct care worker.⁴² Increased retention would also improve quality through better continuity of care for patients.

Higher quality may additionally open the door to potentially higher rates. Though nursing facilities often have little control over the payment levels they receive from government programs, residents who pay out-of-pocket or through private insurance (about 25 percent of residents) may be willing to pay more for a bed in a higher quality facility – leading to a domino effect where improved quality leads to more profitable care for the provider organization.⁴³

Action Needed #3: Treat direct care workers with respect – provide quality training and a career ladder.

Nursing homes vary widely in the amount and type of care they provide, but one pattern is clear – the complexity of required care is outpacing the adaptation of the staffing model in place. Today, most nursing home and assisted living residents have multiple comorbid conditions. They're more likely to have underlying health conditions such as heart disease, hypertension, diabetes, and lung disease,⁴⁴ and roughly 70 percent are living with some form of cognitive deficit, including 48 percent with dementia.⁴⁵ Much of the complexities in care needed for older adults can be attributed to the growth in the “aging in place” movement and advancement of medical technologies, which have led to longer lives and associated greater health care needs. Chris Laxton, executive director of AMDA, the Society for Post-Acute and Long-Term Care Medicine, recently told *The New York Times*, “Nursing homes are really little hospitals, yet they're not staffed like it. If you asked an I.C.U. nurse to take care of 15 people, she'd laugh at you, but that's essentially what we have.”⁴⁶

Given the prevalence of residents with such complex conditions, the CNAs providing them care are often required to juggle multiple clinical responsibilities. For example, a quick look at CNA

job postings in the Maryland area reveals one post describing CNA qualifications as being able to ... “recognize abnormal changes in body functioning” and “perform palliative and post-mortem care.”⁴⁷

To become a certified nursing assistant, the federal government requires that within four months of working at a facility, new nursing assistants complete a minimum of 75 hours of training, including 16 hours of clinical training under direct supervision of a registered or licensed practical nurse.⁴⁸ States are allowed to adjust requirements above this federal minimum, however, and 35 (including Washington, D.C.) have done so – up to a maximum of Maine’s 180 hours.⁴⁹ Kentucky and 15 other states remain at the federal minimum.⁵⁰ These standards have proven to have real impacts on resident well-being. Research indicates that nursing homes in states that required clinical training hours above the federal minimum had significantly lower odds of adverse outcomes – particularly pain, falls with injury, and depression.⁵¹

To deliver quality care under the oftentimes stressful and emotionally taxing conditions that exist in nursing facilities – especially during a global pandemic – CNAs may need more than the minimum 75 hours of training that has been legislated. In fact, in its report on the adequacy of the healthcare workforce for older Americans *Retooling for an Aging America* in 2008, the National Academy of Medicine cited an “immediate need to increase current federal minimum requirements” to at least the 120 hour minimum standard of the top quartile of states.^{52,53} Currently, however, the opposite is occurring. To assist in potential COVID-19-related staffing shortages at nursing facilities, CMS in March lifted the existing 75 hour requirement.⁵⁴ Although the emergency needs of the existing crisis have superseded the underlying need for a more stable, well-trained, and committed direct care workforce, these essential goals should not be overlooked for long. Better trained caregivers lead to lower turnover and higher quality care, which lead to improved resident outcomes no matter what the circumstance – pandemic or otherwise.

In addition to revisiting current training requirements, one strategy to build the skills and longevity of our direct care workforce would be to introduce a career ladder model. Direct care workers need opportunity to grow and learn on their jobs, but too often a support system is not available to allow them to do so.⁵⁵ PHI’s report *Direct Care Work is Real Work* points to a failure to understand the value of direct care workers’ professional contributions as being partially to blame for the lack of a meaningful career ladder.⁵⁶ According to the Institute of Medicine Committee on the Future of the Health Care Workforce for Older Americans, career ladders have been closely linked to job satisfaction, which could reduce turnover (the manifold impacts of which are discussed above).⁵⁷

There are many varied examples – from the federal level down to the individual facility level – of career ladder programs being developed and offered. For instance, in 2008 the Office of Apprenticeship in the U.S. Department of Labor provided grant funding to the Council for Adult and Experiential Learning (CAEL) “with the goal of creating apprenticeship opportunities for direct care workers to develop special skills through on-the-job training, related instruction, and mentoring.”⁵⁸ CAEL’s program took a whole-ladder approach, recruiting nursing home workers from auxiliary areas such as food service and housekeeping and training them for CNA certification. Those at the CNA level were provided opportunities to develop specialized skills in

areas such as geriatrics and dementia care, earning wage increases as responsibilities grew and gradually gaining skills and experience enough to sit for the LPN examination. To help prepare them to sit for the RN licensing exam, LPNs were provided additional opportunities to develop competencies through online and clinical trainings offered in association with local community colleges. CAEL's offering provided a strong proof of concept for the value in encouraging career ladder growth, resulting in "increased retention, reduced recruitment costs, and decreased worker shortages" in the facilities participating in the program.⁵⁹

An important lesson that we've learned from COVID-19's scourge of nursing homes is that stronger federal safeguards need to be firmly planted to secure the lives of residents and staff from a future pandemic. Academics around the world agree that "this kind of event is likely to happen again and again."⁶⁰ Some of those safeguards need to be in the form of minimum federal standards for staffing and training beyond what currently exists. While many states exceed those federal minimum standards, many others do not. As a nation, it is time to raise the bar. The standards we choose to set as a nation can literally mean the difference between life and death for our most vulnerable and frail population.

Policy Recommendation #1: Establish a federal minimum hours per resident per day for RNs and a total nurse staffing.

Relevant Bills

In the House of Representatives: H.R.5216 - **Quality Care for Nursing Home Residents Act of 2019**.⁶¹ Introduced by Rep. Schakowsky (D-IL-9) on 11/21/2019.

This bill calls for providing minimum nurse staffing levels that are sufficient to meet the needs of residents on a 24-hour basis. Dividing the day into three shifts, it would ensure:

- 4.1 hours of care is provided per resident per day, with
- 0.75 hours of care provided by a registered nurse, 0.54 hours of care provided by a licensed practical nurse, and 2.81 hours of care provided by a nurse aide

Related Bill in the Senate: S.2943 – **Quality Care for Nursing Home Residents Act of 2019**.⁶² Introduced by Sen. Blumenthal (D-CT), on 11/21/2019.

Policy Recommendation #2: Increase the federal minimum training hours required to become a certified nursing assistant, with a focus on increasing supervised clinical training requirements.

State Examples of Nursing Assistant Training Requirements Beyond the Federal Minimum:

- **Maine** requires a total of 180 hours (90 of classroom instruction / 90 of laboratory and supervised clinical practice).⁶³

- **Missouri** requires 175 hours (75 of classroom instruction / 100 of on-the-job supervised training).⁶⁴
- **Delaware** requires 150 hours (75 in the classroom / 75 clinical training).⁶⁵
- **California** requires 160 hours (60 classroom / 100 supervised and on-the-job clinical practice).⁶⁶

Policy Recommendation #3: Increase the hourly wage for direct care workers to a living wage in each state.

States Making a First Step Towards Establishing a Living Wage:

- **Wisconsin** established the Governor’s Task Force on Caregiving which, among other things, explores how to pay direct care workers a living wage. One proposal to cover the additional expenses is through annual increases to the existing Direct Care Workforce Funding program.⁶⁷
- **Rhode Island** established the *Health System Transformation Program* that, in part, explores ways to attract and retain the direct care workforce by potentially establishing a “formal wage and job ladders”.⁶⁸
- **Colorado’s** Governor Jared Polis signed into law House Bill 19-2010 in May 2019 allowing local governments within the state to increase their minimum wage higher than the statewide minimum wage. Part of the bill stipulates that any Medicaid nursing facility that resides in a local government that increases its minimum wage higher than the state’s minimum wage is eligible for a supplemental payment from the state to help bridge the gap for the facility to increase its wages.⁶⁹

Policy Recommendation #4: Establish minimum direct care staff-to-patient ratios.

New Jersey Governor Phil Murphy signed Senate bill 2712 into law in October 2020, requiring that facilities maintain a minimum staff-to-patient ratio during morning, evening, and overnight shifts.⁷⁰

The law requires:

- Nursing facilities to have one certified nursing assistant for every eight residents for the day shift,
- One direct care staff member (RN, LPN, or CNA) for every 10 residents for the evening shift, and
- One direct care staff member for every 14 residents for the night shift.^{71,72}

With COVID-19, the importance of adequate nursing home staffing is even more critical in protecting the health and safety of residents.⁷³

PEOPLE – LEADERSHIP

“My philosophy, even from being a very young administrator, was: I do what's right versus what's popular ... When I talk with my staff, I message that all the time, then I role model it ... I have more of a 'servant leadership' type of approach. When my staff are successful, I'm successful. It's not about power, it's about influence.”

– Nursing Home Administrator, Maricopa County, AZ

While the heart and soul of a nursing facility is its staff, the governing mind and central nervous system is its operational leadership, and “leadership”, in this case, is not a theoretical value. It is the compilation of management philosophies, approaches, and choices that can – and have – led to life and death outcomes in nursing facilities. In the midst of a pandemic whose unceasing march has at times led to fatalistic assertions about what is and is not under the control of the leaders of this country's hardest hit industry, we're beginning to gain insight into what actions actually have had positive effect. The staffing decisions so important to rendering proper care and enabling adherence to infection control protocols rest with the leaders who allocate resources and make budget choices. Bringing that staff together in a way that ensures widespread adoption of important safety measures starts with how well leaders are able to communicate and model these important behaviors. And perhaps most importantly, lives can be saved through the actions of leaders who are able to recognize challenges before they hit, who don't wait to be told that action must be taken, and who are willing to look inward and adapt if the shifting landscape once again changes beneath their feet.

Action Needed #1: Build inclusive leadership skills.

In addition to determining what the staffing structure will look like, the leadership style of a nursing home administrator determines the quality of the daily life of staff, and, ultimately, how satisfied and committed to their roles that staff will be. Research indicates that administrator leadership style is directly linked with job satisfaction and staff turnover. A 2008 study published in *The Gerontologist* found that while factors such as wages, benefits, and advancement opportunities played important roles in the intent of nursing assistants to remain in their jobs, “good basic supervision” was the most important factor determining their job commitment and intent to stay.⁷⁴ Staff retention has real impacts on resident outcomes, given that, as discussed earlier, staff turnover negatively effects the quality of care a resident receives.⁷⁵

Nursing home administrators who are consensus managers – those who solicit and act upon input from their staff – are associated with the lowest levels of turnover. Those who are shareholder managers – leaders who neither solicit input when making a decision nor provide their staff with relevant information for making decisions on their own – are associated with the highest turnover levels.⁷⁶ Given these real and measurable impacts on nursing home operations and quality of care that flow from an administrator's leadership style, administrator training, including management skills, is an area that warrants scrutiny when we consider how these facilities can become better prepared to face future health crises when they emerge.

“It’s not the work of one. It’s not because of me, but it’s because of all of us. If you hear somebody in the building say, ‘I did this.’ We will say, ‘Who was with you?’ So that you say, ‘We did this.’ ... It’s that kind of relationship we have established. Nobody is more important than anybody else.”

– Nursing Home Administrator, Hartford County, CT

Leadership requires relationship building with staff. Often relationships are cultivated over time, based on respect and trust. According to an article published in *Nurse Leader*, authentic leaders understand that the leader-follower relationship is achieved when there are mutually shared values. This connection has never been more important – nor potentially more strained – than during the COVID-19 pandemic.⁷⁷ It is tempting, especially under exceptionally stressful circumstances, to brush off the concerns of staff.

“Look, adversity will affect folks. They will either run or they’ll rise. And the question is what will you do? I had a lot of staff that wanted to run because they didn’t want to deal with it ... It’s just fear. Fear is not rational, and fear is not logical.”

– Nursing Home Administrator, Maricopa County, AZ

Harvard Business Review (HBR) recently published an article about preventing burnout during stressful times, such as COVID-19. The article pointed to “Empathetic Leadership” as a road to achieve this means, suggesting that developing mutually shared values will help bridge the divide between leaders and personnel. An empathetic approach requires leaders to step outside their own needs, actively listen to staff, and then take action.⁷⁸

“My staff knew it was not only the safety of our patients that I was concerned about, but their own personal safety. I used to message repeatedly that their job is to protect me from them, and my job is to protect them from me. We all have to keep each other safe. And when we do that, we keep our patients safe. That was the message from very early on. They believed it because it was true.”

– Nursing Home Administrator, Maricopa County, AZ

Inclusive leadership is especially important during periods of stress and anxiety in the workplace. *HBR* also highlights that bringing staff together with “sharing and caring behavior” contributes to staff feeling psychologically safe and helps them stay mentally strong to continue fighting the COVID pandemic.⁷⁹

Case Study. One facility administrator recognized that staff needed emotional support to combat their COVID-related fears and frustrations, so she created a “Talk to Me” program for staff to “just vent and share their concerns.”

The good news is that many of these traits are teachable. In an examination of nursing home administrator leadership styles and their impacts on staff and operations, a 2009 *Gerontologist* study found that leadership strategies are amenable to change. They can be taught in workshops and training sessions.⁸⁰ An earlier *Gerontologist* study additionally indicated that for nursing homes to achieve good resident outcomes, they must have leaders who embrace quality improvement and group processes and who see that residents are provided with the basics of care delivery.⁸¹

Leaders impact their organizations in both measurable and immeasurable ways. As we begin to gain some insight into what factors led to so many lives being lost in this pandemic, it is clear that the role that nursing home leadership has played – in both positive and negative ways – has had real impacts on the levels of stability and focus with which their staff were able to address the challenges that came their way. Style matters, and if nursing facilities are to be prepared for the crises to come, now is the time to begin training leaders to know how style can impact performance and what they can do to better protect the staff and residents under their care.

Lesson Learned #2: Think ahead, be flexible and self-aware

“In any moment of decision, the best thing you can do is the right thing, the next best thing is the wrong thing, and the worst thing you can do is nothing.”

– Theodore Roosevelt, 26th U.S. President

Case Study. In February 2020, a nursing home administrator in Connecticut was watching the news about the nation’s first COVID-19 outbreak at the Life Care Center in Kirkland, Washington. Even though this was happening on the other side of the country, she knew it was time to spring into action. “We thought that it will probably move quickly from state to state, and we might be hit by the virus, so we started planning.” Though she didn’t know if they would be able to keep COVID out because there wasn’t much known about the virus at that time, she wanted to make sure that she understood what was controllable and that the nursing home would be covered if they did get hit. For this administrator, it was clear that staff coverage was a top priority.

Fortify Management. She spearheaded the development of a staffing plan that looked at management responsibilities to determine what action would be needed in case her department supervisors were out sick. The goal was to make sure her staff always had proper supervision.

Ensure Coverage and Listen to Staff. From there, they looked at shift schedules to maximize efficiency if they ever got to a place where staff started calling out sick. The strategy was to potentially switch from eight hour shifts to 12, to allow for three days of work, leaving four days of rest. This plan was devised not from assuming that she knew what was best for her staff, but rather through interviewing them and identifying potential barriers that existed. “We thought we knew each other, but this really gave us an opportunity to know each other more. I think the staff were more open about their problems.” She also looked deeper at the staff’s support systems at home. “We found out who had little ones, who could possibly have a spouse who could take care of the kids. Who had grandparents that they were taking care of.”

Stock Up. The next step was to assess inventory. She reached out to vendors to make sure her facility had enough medical supplies, such as wheelchairs and disposable thermometers. In thinking ahead, she used the knowledge available about COVID-19 in the spring and game planned from there. “Everybody went to work on different categories. We increased our food supply to seven days instead of five. We bought a lot of paper products, thinking that we might not be able to catch up to sanitize all the kitchen products, so we bought paper products so that we could just throw them away and not worry about sanitation.”

Communicate and Educate. While working to prepare operationally, the administrator prioritized information sharing, as well. She made sure that her staff were being educated with the most-up-to-date information on COVID-19 available, and importantly, she also made sure that residents and their family members were involved every step of the way. “We were telling them what was going to

happen, and what we were putting into place. They supported us because they knew that we were planning before it happened.”

Act with Empathy and Offer Recognition. Like most facilities in the U.S., COVID did hit this nursing home, but its presence didn’t impact the consideration that this administrator paid to her staff. “You know when we had deaths,” she explained, “there was just so much I think emotionally where staff will have to say I can’t do this anymore, so we give them a little break. We incurred a lot of expenses because we gave those staff who are, you know, bothered by the whole situation, a time off, and then overtime (for those who covered). Whatever we got with the (Paycheck Protection Program) we gave it to the staff.”

Such flexibility, inclusivity, and sensitivity to the well-being of her staff, residents, and resident families has proven vital. The facility has been one of the best at minimizing mortality in Hartford county, despite others in close proximity faring much worse.

According to the article “Four Behaviors That Help Leaders Manage a Crisis” published in *HBR*, during COVID-19, the best leaders are able to balance incomplete information, conflicting priorities, and their own emotions and anxieties, while simultaneously processing information quickly, and making decisions with conviction. Additionally, strong leaders are able to get ahead of changing circumstances.⁸²

When exploring what went right in nursing homes that have managed to weather the COVID-19 storm more successfully than others, we find countless stories of nursing home administrators taking action early. One such story occurred in Oregon, where, in May of 2020, we found two nursing homes situated just 20 miles apart, in the midst of two very different COVID realities. One was the site of a major outbreak, while the other had zero cases. The latter’s administrator attributed their success to the fact that they’d prepared for the outbreak even before it arrived in the United States. She told CNN, “We had foresight, so we were following the news and saw the outbreaks in other countries happening and knew we were not going to be able to avoid this.”⁸³ The administrator didn’t wait for the government to impose restrictions on nursing homes, rather, she took the initiative to stockpile PPE, started disinfecting items as they came into the facility, and limited the number of staff members each resident had contact with.⁸⁴

“You can either panic during the pandemic or you can be prepared during the pandemic. It’s better to be prepared.”

– Reverend Derrick DeWitt, Maryland Baptist Aged Home

One Baltimore nursing home has a similar story to tell. Located in an underserved neighborhood where median household income is less than \$40,000 per year, the 100-year-old Maryland Baptist Aged Home, with a 90 percent Medicaid resident population, remains COVID-free as of February 2021, despite over 3,000 residents and staff in Maryland’s long-term care facilities losing their lives, accounting for 47 percent of the state’s COVID-19-related deaths.⁸⁵ Maryland Baptist’s record has been remarkable in its own right, but in the face of one disheartening national trend in particular, it becomes simply astounding. According to *The Washington Post*, nursing facilities where at least 7 in 10 residents were Black experienced a death rate that was about 40 percent higher than homes with majority-White populations.⁸⁶ Baltimore’s population is

about 63 percent African American and the city has a poverty rate of over 21 percent.⁸⁷ According to this “zip code”, the prognosis should have been bleak. So how has Maryland Baptist kept COVID out?

Administrator Johana Walburn and Director and CFO Reverend Derrick DeWitt attribute their success to what they deem “the three E’s: being early, excessive and endlessly careful. Don’t ignore; don’t let up; never let your guard down.”⁹¹ They were realistic about the situation facing them. Speaking to *The Washington Post*, Reverend DeWitt explained, “we knew that when the virus came we had to take care of ourselves, because no one else would.”⁹² DeWitt’s intuition in late February led him to push the institution into “full lockdown”.

Visitors were barred, communal meals ceased. The facility began temperature checks three times daily and taking patients’ oxygen levels. It also stockpiled PPE – weeks before shortages began and Baltimore’s first infections appeared.⁹³ Throughout the pandemic, Maryland Baptist’s commitment to being “endlessly careful” has continued. Concerned that his outside activities in the community would expose the residents to unnecessary risk, DeWitt himself didn’t step foot into the facility again until it was time for him to get the COVID-19 vaccine. Reverend

DeWitt has always remained flexible and followed his instincts. Speaking with the Center for Medicare Advocacy, DeWitt remembers, “Past CFOs never went to the nursing home. They just kind of managed from a distance. And I was like, ‘I can’t manage the money if I don’t know what nursing homes do.’ When I went over there, there was no office for me, so I just piled in with the administrator and office manager, in this tight little office.” With his on-the-ground vantage point, DeWitt started questioning the status quo and quickly set his sights on infection control. “The first thing I noticed was that the pyramid was kind of upside-down. The focus was mainly on daily care and very little focus on the long-term outcome for care. I was so dissatisfied with that model. I asked, ‘What is going to keep these people alive longer if it was in our hands?’ And the thing that was killing people was infection. If we can control infection, we could probably give these people a long life. So let’s turn the pyramid upside down and put infection control at the top. We developed protocols, practices, and procedures simply centered around infection control. And we didn’t know a pandemic was coming.”

Residents and staff have also benefitted from a decision made a decade before, when DeWitt hired a full-time infection control nurse – and then committed to keeping the position despite financial downturns along the way. DeWitt recounted, “I got a lot of pressure from people

Spotlight: Racial & Ethnic Minority Disparities

A recent *JAGS* study by researcher Yue Li found that nursing homes that care for disproportionately more racial and ethnic minority residents reported higher new weekly COVID cases and deaths. Li’s research shows that racial and ethnic minorities tend to be cared for in facilities with: (1) inadequate nurse staffing, (2) limited financial and clinical resources, and (3) more care deficiencies.⁸⁸ These circumstances most likely provided fertile ground for COVID to take root and grow.

Adding salt to an already gaping wound, an additional study in *Higher Education & Behavior* shows that older Black Americans are subject to a form of “double jeopardy.” A combination of race- and age-related prejudices, this research shows, leads to poorer health, higher rates of poverty, and ultimately higher risk for COVID-19 exposure.⁸⁹ Furthermore, according to the COVID Tracking Project, Black Americans have died at 1.6 times the rate of white people.⁹⁰

saying, ‘Why would he pay \$90,000 for an infection control person and he only has 29 beds? How can he afford to do that?’ My thing was, ‘How can we afford not to do it? I took a \$20,000 pay cut so that I could bring on the infection control person.’” Such dedication and foresight has left the facility well-prepared to deal with a highly infectious threat like COVID-19, leading to zero infection control citations in the past four years.⁹⁴

Maryland Baptist’s lack of infection control citations further stands out in the face of a recent Government Accountability Office (GAO) study which found that 82 percent of facilities throughout the nation did not similarly avoid these infractions over the five years spanning 2013-2017.⁹⁵ Such statistics as these should raise alarms about the state of nursing facility leadership practices. While the administrators featured above demonstrated the foresight and leadership needed to save lives, there are other examples of nursing home leaders who have made decisions that have had the opposite effect. One such case occurred in Lapeer County just outside of Flint, Michigan, where the Director of Nursing (DON) allegedly told staff not to wear masks. Since they were checking temperatures and didn’t want to alarm residents, the DON told state investigators, she wanted to save that PPE.⁹⁶ While this example highlights the action of the DON, the nursing home’s administrator is equally responsible. As part of the job description, administrators are “ultimately responsible for patient care and business decisions,” including managing “day-to-day operations of the facility and keep(ing) the organization on track for its long-term goals and mission.”⁹⁷

Indeed, Maryland Baptist and other nursing facilities that have managed to keep COVID at bay stand apart precisely because they have not been the norm. Sadly, it’s not hard to find examples of facilities where the pandemic took hold and tore through a population of residents and staff – despite what were likely often the best efforts that administrators felt they could make. COVID has made starkly clear, however, that those in these positions hold significant influence over the health and very survival of the residents and staff under their care and supervision. Such vastly varying outcomes across different facilities must lead us to consider what was different. How can we build upon the examples of those who fared well to correct the practices – well-intentioned though they might often be – of those who fared worse? One area to consider is the standards to which nursing home administrators are held in order to earn and maintain that title.

Though the landmark 1987 Nursing Home Reform Act required the Secretary of Health and Human Services to establish federal standards for administrator licensing, implementing regulations were proposed,⁹⁸ but never issued in final form. Consequently, there are currently no federally mandated cohesive nursing home administrator licensing standards in effect.⁹⁹ Instead, federal regulations direct states in how state-level standards in terms of training, practical experience, testing, and continuing education should be determined and overseen by “the agency designated under the healing arts act of the State” or “a State licensing board”.¹⁰⁰ A national licensing exam has been developed through a collaboration of these state-level oversight bodies under the umbrella of the National Association of Long-Term Care Administrator Boards (NAB).¹⁰¹

Given the lack of a unified national standard, those who are hired to fill these important leadership roles across different geographies bring varying levels of knowledge, skills, and experience to their positions. Currently, 17 states do not require a bachelor's degree or higher to become a licensed nursing home administrator, while 11 states require fewer than twelve weeks of practical training (with seven requiring none). While all states do require candidates to pass the NAB national licensing exam, performance standards vary from state to state and 16 states do not require an accompanying state-level exam. Requirements regarding continuing education hours also vary, with a national average of 31.6 (though 24 states require fewer and three require no CE hours).^{104,105}

Training in Action

Part of gaining licensure in most states requires completion of an Administrator-in-Training (AIT) Program. According to NAB, the AIT experience is a “unique phase of education”¹⁰² which is essentially a supervised internship. Required focus areas include nursing, activities, and human resources. Learning modules include topics such as infection control, emergency planning, evaluating programs to meet the psychosocial needs of residents, and supporting employee satisfaction, and establishing organizational culture.¹⁰³

At the very minimum, nursing home administrators have powerful influence to establish the culture in a facility. That culture impacts staff satisfaction and can either increase or decrease the likelihood a staff member choosing to stay or leave the job. This staff turnover, in turn, impacts the quality of care a resident receives. The COVID-19 pandemic has also shined a powerful light on the life-and-death decision-making role that nursing home administrators play – and the varying degrees to which people serving in these roles have been able to manage their responsibilities. Though state-level considerations are important to take into account, relying on demonstrably diverging standards introduces a level of risk that administrative leadership will not be prepared to keep nursing home residents and staff sufficiently safe. Much work has been done around drafting a federal baseline to which all nursing administrators would be held. Standards governing education, practical training, and continuous skill development have been studied and proposed, but never officially adopted.¹⁰⁶ After COVID-19's devastation of nursing home residents and staff, it is difficult to imagine a more appropriate time to re-examine these standards than now.

Policy Recommendation #1: Establish a federal minimum competency standard for nursing home administrators to gain licensure, including incorporation of minimum hours for continuing ed and AIT practical experience.

Examples from Other States:

- 19 states require 1,000 hours or more training (e.g., California, Maine, and Louisiana)
- Of those, 3 require 2,000-2,080 hours (Delaware, Maryland, and Hawaii)

Room for Growth:

- 32 states range from 0 hours (e.g., Wisconsin) to less than 1,000 (e.g., Connecticut, which requires 900 hours)¹⁰⁷

SECTION 3: ACTIONS NEEDED – PLACE

In April 2020, merely three months after the United States saw its first case of COVID-19, CMS Administrator Seema Verma declared that nursing homes were “ground zero” for the pandemic.¹⁰⁸ Why nursing homes? They are – by design – congregate living environments, the best of which should be “lively place(s) with many ties to the larger community,” as described by Robert Butler in his 1975 Pulitzer Prize-winning hallmark text on growing old in America, *Why Survive?* We soon learned that, sadly, it was the very nature of these facilities – which in the best cases offer residents an environment that allows them to connect with those around them – that provided such fertile ground for COVID to spread. Because of these factors, at the time, there seemed to be no better way to protect the most vulnerable than to lock out the outside world as much as possible, and so in March 2020, CMS directed nursing homes to do just that, restricting entrance of “all visitors and non-essential health care personnel.”¹⁰⁹

The drastic action of locking down facilities – justified though it might have been by public health necessities – has had unintended impacts on other areas of nursing home residents’ well-being. The disastrous mental health effects that total lockdowns have had on residents have been well documented. Social isolation and loneliness have been associated with, among other things, premature mortality, higher risks of cognitive impairment, and emotional distress such as anxiety and depression.^{110,111} Looking beyond the pandemic, it will be essential to create policies and plans that will protect nursing home residents’ physical and mental health when faced with a similar crisis as that which presented itself with COVID-19. A broad brushstroke approach that rests on cutting residents off from the outside world introduces both clinical and ethical concerns. It never should be lost that these “facilities” are *home*, at their most meaningful level for those who live there.

The 1987 Nursing Home Reform Act strengthened the Nursing Home Resident’s Bill of Rights, which requires that residents have the right to “welcome or refuse visitors”, “exercise self-determination”, “communicate freely”, and “participate in resident and family groups”¹¹² – all of which have been curtailed during the pandemic emergency. It is essential that we do not forget that these rights are paramount and find alternative ways of protecting residents and staff. As Eleanor Roosevelt famously said in 1958, “Where, after all, do universal human rights begin? In small spaces, so close to home – so close and so small that they cannot be seen on any maps of the world. Yet they are the world of the individual person.”¹¹³

Though it can be difficult to counter risks imposed by long-term care facilities’ physical infrastructure, there are several very clear lessons that we can take away from the pandemic experience. The key lies in the choices that nursing home administrators, care staff, and ownership can control – both in terms of how residents are housed, and by factoring in those essential community ties that Robert Butler described.

Action Needed #1: Limit the number of residents per room.

Over the course of the COVID-19 pandemic, we have all come to appreciate the importance of space and spatial practices like social distancing, isolation, and quarantine. In a congregate living settings, however, where closely quartered older adults are at particular risk for greater infection

rates and mortality, learning how to manage the built environment becomes central to any infection control strategy.

The physical environment of nursing homes presents both opportunity and challenges. On one hand, reducing crowding and increasing private spaces provides demonstrable risk reduction solutions. According to a *JAMA Internal Medicine* study which examined the association between nursing home crowding and COVID-19, COVID-19 incidence in rooms and bathrooms with a higher number of people per room (“high crowding”) was 9.7 percent compared to 4.5 percent with a lower number of people per room and bathroom (“low crowding”). Furthermore, the death rate was higher in those rooms and bathrooms with more people (2.7 percent) vs. COVID-19 deaths in rooms with fewer people (1.3 percent).¹¹⁴ While not the norm in nursing facilities, private rooms with bathrooms are also linked to quality of life and improved overall infection control, and they can be used both to facilitate visitors and to isolate confirmed or suspected COVID-19 cases.¹¹⁵

On the other hand, however, it’s not always easy to find or create the necessary infrastructure that is needed to reduce the number of beds per room. Outdated infrastructure creates significant obstacles at midcentury facilities that were designed to house more than two residents per room. In Massachusetts, for example, despite a 2000s-era law that required single occupancy rooms for new facilities, existing properties were grandfathered in and were therefore not required to comply.¹¹⁶ According to a Manatt study assessing New Jersey nursing homes, this type of infrastructure issue contributed to COVID’s impact on that state. “Certain characteristics of New Jersey nursing homes – which are not unique to the State,” the report reads, “put them at particularly high risk of an outbreak ... New Jersey has many old facilities, many with 3- and 4-bedded rooms.”¹¹⁷

Existing federal regulations hold that states must ensure that facilities house no more than four residents per room.¹¹⁸ Given the lifestyle and well-being benefits of housing fewer residents together, however, at least 25 states have chosen to lower those caps – whether through standard guidelines, or in association with new construction or certificate of need approvals.¹¹⁹

In many ways, COVID-19 has changed how each of us considers risk. What may have seemed acceptable before – like eating in a restaurant or going grocery shopping without wearing a mask – is, for many, no longer worth the gamble. Nursing home crowding can be viewed similarly. While the prevalence of state restrictions that surpass federal guidelines seems to indicate that the benefits of limiting the numbers of beds per room are often known and accepted, real obstacles have stemmed more widespread change. Now that it is clear that these choices have consequences that can be measured in lives, however, nursing home operators and legislators must strongly consider the level of risk they are willing to take on. Already, states have begun recognizing and acting upon the knowledge that fewer beds means safer environments, healthier residents and staff, and reduced burden on the healthcare system overall. Policymakers should look to these early examples as guidelines to how they might similarly help prevent a repeat of the destruction that this pandemic has wrought on our vulnerable nursing home populations.

Policy Recommendation #1: Revise current federal regulations which set the maximum number of residents per room to four – limit occupancy to two residents per room.

One State’s Implementation:

Massachusetts announced a Nursing Facility Accountability and Supports package in September 2020, which includes \$60 million of targeted COVID-19 funding for nursing homes, contingent upon facilities converting three- and four-bed rooms into singles or doubles. Facilities will also have to increase the minimum square footage in rooms by January 2022.¹²⁰

Action Needed #2: **Make it a home** – prioritize social connection and engagement of residents.

Humans are social animals. Throughout history, when challenges have arisen and survival has been at stake, we’ve persevered by joining forces to face adversity. It’s that support system that has allowed us to thrive – as a species, as a society, and as individuals. One of the tragedies of this pandemic is that COVID-19 has turned that strength into a vulnerability. Through breath, through contact, through gathering, through touch, laughter, sharing, and singing – through the very means we have at our disposal to seek support and fortification – COVID-19 hitches a ride and delivers illness, pain, and death. So we mask up, we keep our distance, and, to protect vulnerable older adults living in congregate settings, we shut the doors and keep the carriers – each other – away.

Nursing home residents have suffered in so many ways over the course of this pandemic, but perhaps no more heart-rendingly than through the impacts they have felt by being cut off from their families, friends, and each other. “Social isolation is a potent killer,” declared the American Academy of Social Work and Social Welfare (AASWSW).¹²¹ It is one of the most tragic lessons learned over the course of this pandemic, and we must emerge with the conviction to find a better path.

Before COVID-19 became a daily reality, loneliness in older adults was already a worrisome issue. As a person ages, the likelihood of experiencing age-related loss increases, and those losses breed loneliness.¹²² According to Health Resources & Services Administration (HRSA) statistics, the reality for older adults is sobering. Before the pandemic, almost one-half (43 percent) of older adults felt lonely on a regular basis. Of those who were feeling lonely, the risk of mortality increased by 45 percent.¹²³ The health impacts of loneliness are real. It is as destructive to a person’s health as smoking 15 cigarettes a day.¹²⁴ During COVID-19, in fact, some death certificates have read “failure to thrive” in cases where doctors believe the despair and desperation of being cut off from loved ones played a significant role.¹²⁵ Social isolation, which instigates and feeds loneliness, has been a longstanding issue for which experts have yet to find meaningful solutions.¹²⁶ It’s for this reason that, in 2015, AASWSW included the goal of reducing social isolation and loneliness as one of the twelve “Grand Challenges” of the social work profession.¹²⁷

“You can actually really see depression. They don’t want to eat. They’re ‘always full’ even if you know they did not eat. Weight loss. You know their affect will really tell you that they miss their family.”

– Nursing Home Administrator, Hartford County, CT

So how do we combat this epidemic within a pandemic?

Activity Coordinators. There are resources in place at nursing homes that offer a suitable start. Activity coordinators who are involved in choosing, planning, and carrying out recreations and events for residents have been crucially important during this time.¹²⁸ In response to CMS’s lockdown directive, facilities have scrambled to find ways to keep residents occupied and engaged. The best got creative. One nursing home touts activities such as “hallway bingo” (playing the game in their open doorways), hallway karaoke, and socially distanced exercise sessions.¹²⁹ The Maryland Baptist Aged Home’s response included hiring “an extra activities person to help do puzzle books and painting and making clocks and birdhouses out of cigar boxes we collected.”¹³⁰

Other facilities, however, have not stepped up their engagement activities – with grievous outcomes. A recent report by Altarum that directly polled residents about their experiences during the pandemic revealed that 54 percent reported they were not participating in any organized activities, such as exercise and art classes, while 76 percent said they felt lonelier under the restrictions.¹³¹ One resident said, “I feel worthless and most days I feel like giving up, and I’m usually an upbeat positive person. The facility needs to create a safe way for me to see my spouse and not keep me locked up in a tiny room. Hopefully I won’t die from the way I’m now being treated.”¹³² A recent article in *The New York Times* depicts that a resident told a worker one evening that she was the first person she had seen all day.¹³³

“Our Activities department has really turned into a Communications department. They take iPads around and get FaceTime going or Skype or whatever platform families have. We do have families that come to the windows and see them and use iPads at the same time ... Virtual visits have become really important.”

– Nursing Home Administrator, Los Angeles County, CA

Virtual Visits. Virtual visits have become a lifeline for many locked down residents and their loved ones desperate to maintain connection, and while these digitally enabled sessions have helped fulfill some of the human contact needs required to stave off severe loneliness and depression,¹³⁴ there are limitations. Nursing homes often don’t have enough equipment, older adults might not know how to use the technology, and some older adults who are cognitively impaired are simply confused by the experience and don’t get the benefits of the connection that a virtual visit is intended to supply.

Virtual Visit Challenges

Access. In a recent AARP profile, one nursing home resident described her facility’s limited number of phones as a problem, saying, “It’s so hard to get those portal phones from the nurses, because they need it. And somebody else might have it, or they have to charge it. You can’t always get it when you want it. So I don’t ask for it that often.”¹³⁵ This resident’s experience does not appear to be atypical. A 2019 analysis published in *JMIR Aging* assessed the extent to which nursing homes had IT capabilities that allowed residents access to technology. It was found that 86 percent of facilities analyzed (n=815) scored a 0 on their resident access to technology score, indicating that no resident had access.¹³⁶

Skills. AARP’s profile illustrates another challenge that older nursing home residents face in using digital technologies – their reliance on staff to help coordinate these connections. A recent study published in *The Journals of Gerontology* argued that relying only on “digital events” for social participation during COVID-19 could perpetuate the stigma of ageism – where older non-users of technology are viewed as outsiders – essentially, ushering in an additional form of social exclusion.¹³⁷

Cognitive Ability. According to the CDC, about 48 percent of nursing home residents have some Alzheimer’s Disease or some other form of dementia,¹³⁸ which is a conservative figure. Other accounts bring the percentage to over 70 percent.¹³⁹ For those with cognitive impairments, virtual visits are not necessarily enough to provide the social connection needed to survive. Touch is essential for Alzheimer’s or dementia sufferers. It can calm agitation, reduce physical discomfort, and promote sleep. Since those with Alzheimer’s or dementia can have difficulty with communication, touch also promotes emotional connection to others.¹⁴⁰ That emotional connection cannot necessarily be made virtually. It is also key to helping residents in their fight against the disease. Social and mental stimulation are two of the precious few tools available to help slow dementia’s progression.¹⁴¹

Loved ones, too, need the kinds of in-person interactions that COVID-19 has transformed into a life-and-death risk. The lengths some family members have gone to in order to connect with their loved ones reveals deep levels of commitment. One woman in Boston found that FaceTime was confusing for her mother, who is in her 90s and suffers from dementia. Concerned about the impact of not having in-person visits, she decided to take a night job working in the laundry room at her mother’s nursing home. The daughter is grateful for this chance to enter her mother’s home: “She really came back. I said this is worth the laundry ... when something gets in your way, find a way around it. I’m lucky I’ve been able to.”¹⁴²

Policy Recommendation #1: Establish an “essential caregiver” for residents in federal law.

Examples from States with Essential Caregiver (EC) Initiatives:

- **Nebraska:** Governor Pete Ricketts announced an initiative in December 2020 to allow ECs into the state’s long-term care facilities. These caregivers are allowed to observe and communicate important details about a resident’s condition, while also providing much-needed emotional support. Under this plan, the essential caregiver works directly with individual residents for about three hours per day at the facility.^{143,144}
- **Minnesota:** In October 2020, the Minnesota Department of Health announced it would consider EC visits as a type of compassionate care because “while technology can help decrease loneliness for some residents, technology is not a sustainable replacement for in-person contact. This is especially true for residents with cognitive impairments.”¹⁴⁵
- **Indiana:** The Department of Health “Visitation Guidelines for Long-Term Care Facilities” states that “visitation should be allowed in compassionate care circumstances ... such circumstances include when ... a resident, who used to talk and interact with others, is experiencing emotional distress ... A resident’s relative or other loved one is an essential caregiver for the resident.”¹⁴⁶
- **South Dakota:** “Health care workers who are not employees of the facility but provide direct care to the facility’s residents, such as ... essential caregivers ... must be permitted to come into the facility.”¹⁴⁷

Policy Recommendation #2: Mandate the designation of a virtual visit coordinator to ensure residents have continued access to loved ones and telehealth options.

Examples from State Initiatives

New Jersey: Manatt recommended that New Jersey require nursing homes to dedicate a staff member to manage communications across residents, their families, and other representatives, including supporting residents with technology for personal calls and telemedicine.¹⁴⁸

SECTION 4: ACTIONS NEEDED – PROTOCOLS

“I felt like we were at war. My men and women were getting shot and falling each day.”

- Nursing Home Administrator, LA County, CA

Over the course of this pandemic, at the most fundamental level, nursing home residents, staff, and administrators have been engaged in a life-and-death conflict with an invisible agent whose strengths and weaknesses have not always been

known. This mystifying disease has left the members of this most vulnerable community grasping for a plan – some way to prepare for and respond to the very real and frightening threat they found seeping through their doors. To borrow from the analogy of war described by the administrator

quoted above, how do you confront an enemy that you cannot see, detect, or know? Frightening as this prospect might be, considering what we *do* know goes a long way to make it less so. After all, COVID-19 is, if nothing else, an infectious disease, and nursing homes have decades of experience based on volumes of guidance about how to manage and ward off such threats. Why, then, has COVID-19 found such fertile ground in these facilities? If there are so many protections already in place, why weren't nursing homes able to fend off a disease whose strengths and weaknesses – though more amplified – were fundamentally the same as many others?

“We’ve always had a bug that we’re fighting ... It was C. Diff the last 5-10 years. Before that, it was MRSA ...”

- Nursing Home Administrator,
Maricopa County, AZ

As our knowledge of COVID-19 has grown, one insight into the virus's behavior has become clear – this disease has an uncanny ability to uncover vulnerabilities that already exist and exploit them to deadly effect. In human physiology, this trait means that those with underlying conditions – whether known or not – are most at risk. Examining this disease's progress through our nation's nursing homes, we see the same pattern emerge.

The U.S. Government Accountability Office (GAO) released a report in May 2020 revealing that from 2013-17, infection prevention and control (IPC) deficiencies were the most common type of deficiency cited in nursing homes.¹⁴⁹ In that five-year period, fewer than 20 percent of the nursing homes in the United States escaped this type of citation. Furthermore, in each individual year from 2013 through 2017 – for five straight years – the percentage of nursing homes with an IPC deficiency ranged from 39 to 41 percent.¹⁵⁰ According to the GAO, this pattern is “an indicator of persistent problems”¹⁵¹ – problems that offered COVID-19 the opportunity to take hold, spread, and wreak devastation on the residents and staff living and working in these facilities.

“Infection control is not a new game ... so, you know, in that regard, if a facility has been good about its infection control practices all along, then COVID is a different method of transmission ... but it's still a function of infection control. It's still practicing good hand hygiene, wearing protective gear and all the rest ... and so in that regard, if a facility has always been good about that to begin with and continues to be good about that ... you will see less spread.”

- Nursing Home Administrator, Maricopa County, AZ

For a disease that targets vulnerabilities in a system, COVID-19 found the perfect opening in widespread infection control discrepancies that have been allowed to go unchecked in nursing facilities for years. With the rollout of vaccines now underway, nursing home residents and staff will soon be provided the best armor possible in their battle against this deadly disease, but new threats will arise. The key to protecting lives in these inevitable future battles will rest in shoring up the foundational infection control and enforcement system that, in the case of the COVID pandemic, has failed to offer the insulation from viral threat that it was designed to provide.

Three strategies can help achieve that goal:

1. Prioritize enforcement of infection control deficiencies
2. Build up the infection prevention infrastructure and system of planning/preparation
3. Better align federal and state coordination and communication with public health guidance

Action Needed #1: Prioritize enforcement of infection control deficiencies.

Looking again at the GAO’s finding that 82 percent of U.S. nursing homes had been cited for infection prevention and control deficiencies, one other insight stands out: about 99 percent of those deficiencies were classified as “not severe”,^e of which only one percent had any enforcement action actually imposed.¹⁵² While these “no harm” infractions may not have put residents into what CMS defines as “immediate jeopardy”,^f they do include citations such as improper hand washing and failing to wear proper protective gear.¹⁵³

Over the course of the COVID-19 pandemic, infection control has been put under a more focused lens. In March 2020, CMS suspended its regular survey-based oversight process and announced instead that it would conduct limited surveys that focused on infection prevention and control issues.^{154,155} Each month, the Center for Medicare Advocacy (CMA) has analyzed this data, finding that, as of the November 18th cumulative release, 9.3 percent (4,918) of the 52,680 facilities surveyed since March were cited for infection control deficiencies – at least one citation in each state. Despite soaring death rates in nursing homes across the country, however, “immediate jeopardy” citations have still remained surprisingly low. Of those facilities cited, only 6.4 percent (314) were found for this highest level of infraction.¹⁵⁶

Additionally, between March 23rd and May 30th, 2020, states conducted onsite surveys at 31 percent of the nursing homes around the nation. According to an OIG report, surveyors cited only 68 infection control deficiencies (compared to about 10 times this amount the prior year).

^e The GAO report classified “not severe” as meaning that surveyors determined the deficiency was either a Level 1 (no actual harm with a potential for minimal harm) or Level 2 (no actual harm with a potential for more than minimal harm, but not immediate jeopardy).

^f CMS defines “immediate jeopardy” as including three key components: (1) Noncompliance with one or more federal health, safety, and/or quality regulations; (2) Serious Adverse Outcome or Likely Serious Adverse Outcome as a result of the noncompliance has occurred, is occurring, or is likely to occur to one or more identified recipients at risk; (3) Need for Immediate Action by the provider/supplier to prevent serious injury, serious harm, serious impairment or death.

Among those deficiencies, the most common involved improper use of PPE, dirty surfaces, and lapses in hand washing.¹⁵⁷

These low levels of citations and penalties do not reflect a nursing home industry that has performed well in the face of this deadly disease. A *Washington Post* analysis in October found that “all told, homes that received a clean bill of health earlier this year had about 290,000 coronavirus cases and 43,000 deaths among residents and staff.”¹⁵⁸ Even among facilities that were fined, many received minor penalties despite high levels of COVID-19 infections and deaths: “For failing to ensure staff members wore masks, Sterling Place in Baton Rouge, with more than 80 coronavirus cases and 15 deaths, was fined \$3,250,” their analysis found. “For failing to separate residents in a common area, Heritage Hall in Leesburg, Va., with more than 100 cases and about 18 deaths, was fined \$5,000. For failing to use protective gear, the Broomall Rehabilitation and Nursing Center in Pennsylvania, with more than 200 cases and about 50 deaths – among the highest nursing home death counts in the country – was fined \$9,750.”¹⁵⁹

Given the experience of the nation’s nursing homes over the course of the COVID-19 pandemic, it would be worthwhile to re-examine two key enforcement areas that, taken together, have the potential to open the door to greater infection control oversight and stronger practices in nursing facilities across the country. They are: (1) how we define acceptable risk for residents when it comes to infectious disease infractions, and (2) how we levy penalties against those facilities found to be most out-of-line with safe practices.

Defining Acceptable Risk. In March of 2019, almost exactly one year before COVID-19 began its tear through our nation’s nursing homes, the Trump administration made a small change to surveyor regulations that made applying the “immediate jeopardy” tag to most infection control infractions more difficult. In a set of revisions to its “Appendix Q” to the “State Operations Manual”, CMS changed the definition of “Immediate Jeopardy” to require the “likelihood” of serious harm, replacing the “potential” for serious harm definition that had existed since the Nursing Home Reform Act of 1987 was passed.¹⁶⁰

Replacing the word “potential” here with “likelihood” may seem like a small change, but when it comes to infectious disease, small things are everything. One can see where, during more “normal” non-pandemic times, smaller infection control infractions would not be deemed to have the “likelihood” to cause serious harm. In the world that exists now, however – the one where it has become very clear that older adults are highly vulnerable to deadly infections that can creep through our nation’s nursing facilities’ walls at any time – it should be evident that these small infractions certainly have the “potential” – at all times – to cause residents serious harm. Consumer Voice, an organization representing consumers in issues related to long-term care, noted its concern about this language change, stating, “we wonder if the elimination of the term ‘potential’ and the inability for surveyors to use the same set of facts in multiple (immediate jeopardy) deficiencies will mean serious harm or likely serious harm will be unidentified and therefore unaddressed, leaving residents at risk.”¹⁶¹

Levying Penalties. One consistent focus of the Trump administration has had significant downstream impacts on the safety of nursing facility residents around the country – the reduction of fines. In July of 2017, CMS issued a revision to its Civil Money Penalty (CMP) policies that

told Regional Offices around the country to limit the use of “per day” penalties for infractions found during a survey visit (replacing them with much lower “per instance” levies).¹⁶² In June of 2018, CMS issued further guidance, removing mandatory fines and instructing Regional Offices to “determine the most appropriate remedy” when an immediate jeopardy infraction “does not result in serious injury, harm, impairment or death.”¹⁶³ These policies have borne themselves out in the numbers. According to *The Washington Post*, “Over the past two years, total fines dropped 10 percent from their highs in 2016 and 2017 and are down significantly so far (in 2020),” as well.¹⁶⁴ Levying lower fines with greater discretion has allowed some nursing homes to violate important infection control standards, putting residents at risk, with little consequence. “A lot of the fines are so low they’re just considered the cost of doing business and companies pay them routinely,” Alice Bonner, director of the CMS division of nursing homes from 2011 to 2013, told *The Washington Post*.¹⁶⁵

Despite the old adage to the contrary, rules are meant to be followed, not broken. Without the ability to uncover, name, and enforce violations of vital infection control standards meant to protect the lives of our nation’s nursing home residents and staff, we will be destined to re-live the same type of devastation we have experienced over the course of the COVID-19 pandemic. One truth has become abundantly clear: deadly contagions do not heed the needs of those who seek to skirt the important established rules. Infectious agents respond to two things – control and enforcement. We must do everything we can to shore up our strengths in these areas if we’re to emerge from this crisis stronger than we entered it.

Policy Recommendation #1: Re-strengthen the definition of immediate jeopardy – replace “likelihood” for serious harm with “potential” for serious harm.

Policy Recommendation #2: Roll back Trump Administration loosening of Civil Money Penalty (CMP) sub-regulations

Policy Recommendation #3: Prioritize infection control deficiency oversight during and post the COVID-19 crisis

Action Needed #2: **Build up the infection prevention infrastructure and enforce pandemic preparation rules.**

The Nursing Home Reform Act of 1987 (NHRA) established that residents must receive “quality care that will result in their achieving or maintaining their ‘highest practicable’ physical, mental, and psychosocial well-being.”¹⁶⁶ The rules and guidelines set forth in this historic legislation established a framework that has proven strong and effective in achieving these aims. In 2016 the Obama Administration issued two new rules that sought to build upon this infrastructure to address areas that would prove especially relevant to nursing home preparation for the COVID pandemic –infection prevention and control (IPC) and emergency preparedness.

Infection Preventionist. CMS’s “Reform of Requirements for Long-Term Care Facilities” rule (2016) provided that its regulatory changes were “necessary to reflect the substantial advances that have been made over the past several years in the theory and practice of service delivery and safety.” The revisions, the rule states, “are also an integral part of (CMS’s) efforts to achieve

broad-based improvements ... in the quality of health care furnished through federal programs, and in-patient safety.”¹⁶⁷ CMS’s 2016 rule, in part (§ 483.80), provides time-boxed requirements around the establishment of the kinds of IPC standards that have become nursing facilities’ primary defenses against COVID’s deadly threat. In summary, these new infection control requirements hold that:

- 1) Within 30 days, facilities were obligated to establish an IPC program.¹⁶⁸
- 2) By November 2019, facilities needed to designate at least one part-time infection preventionist who must “have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; ... be qualified by education, training, experience or certification; ... work at least part-time at the facility; and ... have completed specialized training in IPC”.¹⁶⁹

In what it described as an effort to reduce regulatory burden, however, in 2019 the Trump Administration proposed rolling back some of these new regulations. One such proposed change – still pending as of the writing of this report – was to remove the existing requirement that the infection preventionist work at the facility at least part-time, instead requiring that the person in this role have “sufficient time” onsite.¹⁷⁰

Looking beyond the obvious red flags that would be raised should this proposed change go into effect in the midst of a deadly pandemic, there is at least anecdotal evidence that the mere presence of such a proposal could have sown enough confusion or – more cynically – provided justification, for bottom-line focused nursing home operators to delay hiring an infection preventionist in time to meet the November 2019 deadline for doing so. One administrator interviewed for this report was recently hired at a new facility and found mistakes that likely contributed to challenges controlling COVID-19 outbreaks, resulting in multiple resident deaths. Interviewed in December of 2020, this administrator explained:

“We don’t have an infection preventionist. It is completely nonexistent in this building.”

- Nursing Home Administrator, Maricopa County, AZ

While this administrator described the decision as being determined by the previous director of nursing, who “didn’t see the value” in an infection preventionist, as COVID-19 has taught us, safety is not subjective for nursing home residents. This flagrant dismissal of protocol is precisely the type of situation where state and federal authorities cannot look away, and where strengthened enforcement tools could provide the “stick” that is needed to hold derelict facilities accountable.

Thankfully, when COVID-19 began spreading through our nation’s nursing homes, the Trump Administration’s proposed loosening of 2016’s infection preventionist requirements came under fire and were even contradicted by other areas of the executive branch. In May, the Centers for Disease Control (CDC) issued recommendations that facilities with 100 beds or more should employ “at least one person” in a “full-time role” to “provide on-site management of the IPC program.”¹⁷¹ Importantly, the CDC emphasizes that this recommendation “should remain in place even as nursing homes resume normal activities.”¹⁷²

In its COVID-19 response recommendations report issued to the state of New Jersey, Manatt recommended surpassing the federal standards to mandate that every nursing facility in the state have a senior-level Infection Control Preventionist who reports to the CEO and the Board of Directors. Similarly to the CDC, Manatt recommended that for 100+-bed facilities, this position should be full-time without any other responsibilities.¹⁷⁵ A Mathematica report to the state of Connecticut, meanwhile, recommended that the state broaden its qualifications for the infection

preventionist position and expand the role to be full time in all nursing homes no matter the number of beds. It also recommended that Medicaid payment rates be adjusted to cover the extra cost of the full-time positions.¹⁷⁶

Infection Prevention in Action:

Command Center: In April 2020, as Massachusetts nursing homes became a battleground for COVID-19, Governor Charles Baker allotted \$130 million in additional nursing home funding for two months. That funding was contingent on compliance with a new set of care criteria. Part of the plan included an “infection control command center” which would provide infection control protocols and trainings, in addition to providing on-the-ground, infection control specialist support and intervention for those facilities that needed it most.¹⁷³ Data collected showed that facilities deemed “special focus” were able to rapidly decrease their resident and staff infection rates.¹⁷⁴

With the Biden administration stepping in, we have an opportunity to correct some of the dangerous leanings of the prior. Had 2016’s rule changes been rolled back to the level proposed in 2019, it is very likely that the devastation our nation’s nursing homes have experienced could have been even worse. Rules and guidelines matter. In fact, a recent comparative analysis in *JAMDA* examined nursing home IPC practices in 2014 vs. those in place in 2018 – a period inclusive of the 2016 Obama administration rule change described above. The study found that outbreak control practices improved by 13 percentage points, including a 17 percent increase in the number of facilities that had

established protocols for resident confinement in the case of an outbreak. “Policy mandates and greater national attention,” the authors argue, “are likely important factors in improving nursing home infection prevention and control practices.”¹⁷⁷

Policy Recommendation #1: Implement at least the CDC’s recommendation of one full-time sole-focused infection preventionist (IP) as the minimum federal standard.

Emergency Preparedness Plan. The second 2016 NHRA update most closely aligned with ensuring preparation for the COVID-19 pandemic that was lurking around the corner came in the form of CMS’s “Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers” rule. CMS’s new rule put into place standards designed to help all health care providers and suppliers, including nursing facilities, “plan adequately for both natural and man-made disasters.”¹⁷⁸ Stemming from a review of existing Medicare emergency preparedness requirements and their failures in the face of modern disasters such as “the catastrophic hurricanes in the Gulf Coast states in 2005, flooding in the Midwestern states in 2008, the 2009 H1N1 influenza pandemic, tornadoes and floods in the spring of 2011, and Hurricane Sandy in 2012,” CMS’s rule lays out elements that it deemed “central to an effective and comprehensive framework of emergency preparedness requirements.”¹⁷⁹ These include:

- 1) Risk assessment and emergency planning
- 2) Development of policies and procedures
- 3) Creation of a communications plan
- 4) Training and twice-annual drilling/testing

Despite what some advocates described as these “pretty basic” safeguards, nursing home operators pushed back. “We are concerned that CMS has underestimated the amount of time, training and resources necessary to implement many of these requirements,” one long-term care operator wrote in a formal response to the proposal.¹⁸⁰ Industry lobbying groups doubled their efforts with the arrival of the Trump administration, winning some concessions (such as the elimination of a requirement to document coordination with local authorities), but when it came to the inclusion of a pandemic preparedness provision, CMS stood its ground.¹⁸¹ In 2019, in fact, the agency released a separate guidance specifying that hazards addressed by plans should “include emerging infectious disease (EID) threats.”¹⁸²

But nursing homes were still caught off-guard. Why?

“I hate to say this, but I think every administrator, in every company ... if the policy doesn’t really pertain to them immediately, then they’re not going to take a look at it. It wasn’t until we had this epidemic where (ownership was) like, ‘Oh my God, maybe we should reassess our policies!’”

– Nursing Home Administrator, LA County, CA

David Grabowski, professor of health care policy at Harvard Medical School, told *ProPublica* in May that while some facilities do make concerted efforts to safeguard their residents in case of disaster, many others do not – “somewhat because CMS hasn’t forced this and really held their feet to the fire.”¹⁸³ According to their July 2020 report on nursing home failures during COVID-19, Senators Bob Casey, Gary Peters, and Ron Wyden would concur, concluding that when it came to emergency preparedness failures “homes rarely face severe reprimands ... even when inspectors identify repeated lapses.”¹⁸⁴ In other words, emergency preparedness planning has proven to be another casualty of the same weak enforcement practices discussed above.

In fact, *ProPublica* additionally reports that “in 2019 and 2020, the HHS inspector general found that inspectors in at least five states – California, New York, Florida, Texas and Missouri – were not thoroughly policing the new emergency preparedness rule.” According to Justice in Aging’s directing attorney Eric Carlson, the reason parallels those articulated above in the infection control deficiency discussion. Inspectors more focused on uncovering “immediate hazards” (as defined in the pre-pandemic world) have likely been less focused on scrutinizing facilities’ emergency plans, he argues.¹⁸⁵ Despite this apparent lack of scrutiny, however, when emergency preparedness citations do occur, we begin to gain some insight into the potential dearth of pandemic-specific planning happening in these facilities. In California, at least 56 facilities were cited specifically for a lack of a pandemic plan.¹⁸⁶

“We had an emergency preparedness plan before [COVID-19], but did it have a pandemic like this? I don’t know if it even addressed something like this. Probably not ... We were just doing whatever we could to keep it out.”

– Nursing Home Administrator, LA County, CA

These types of preparation gaps help explain why many nursing homes were caught playing catch-up when COVID began spreading through their halls.

For years, nursing home residents have suffered when their facilities have shown themselves to be unprepared to face localized crises like flooding, storms, and infectious threats. The need for change was so clear that an effort begun in the George W. Bush administration was picked up and brought to fruition by the Obama team that followed.¹⁸⁷ It is beyond unfortunate, then, that despite these bipartisan efforts to protect residents from precisely the type of threat they are facing today, a lack of follow-through has stood in the way, costing untold numbers of lives.

The COVID-19 crisis must be the last time our nation’s elders fall victim to the inability of their facilities to protect them in times of emergency. It falls to the operators of those facilities and the regulators who oversee them to not just set proper emergency preparedness standards, but to make sure that those standards are enforced, for as Melanie McNeil, Georgia’s long-term care ombudsman told *ProPublica* in May: “Facilities should have been better prepared for this. The cost is human lives. That’s the cost of not being prepared.”¹⁸⁸

Policy Recommendation #2: Review current emergency preparedness requirements to determine if changes are needed to ensure residents are protected against future pandemics; focus on enforcing these standards.

Other Examples of Recognized Need for Strengthening Emergency Preparedness:

Report: In their *COVID-19 In Nursing Homes* report, Senators Bob Casey, Gary Peters, and Ron Wyden cited that the disproportionate impact of COVID-19 on nursing homes, in addition to the impacts of previous emergencies, demonstrated the need for emergency management and response reforms, including increased emphasis on prevention for infectious diseases.¹⁸⁹

Report: The Coronavirus Commission on Safety and Quality in Nursing Homes recommended in their “Action Steps” to “add a requirement in the Emergency Preparedness regulation (42 C.F.R. §483.73) to include PPE utilization in emergency preparedness and infection control protocols.”¹⁹⁰

Audit: HHS’s Office of Inspector General (OIG) is currently conducting an audit of nursing home infection prevention and control program deficiencies. The objective of this audit is to determine whether selected nursing homes have programs for infection prevention and control and emergency preparedness in accordance with Federal requirements. That report is expected to be released in FY 2021.¹⁹¹

Action Needed #3: Better align federal and state coordination and communication around public health guidance

In late January 2020, the coronavirus was declared a public health emergency and President Trump announced the formation of the White House Coronavirus Task Force, whose purpose was to “coordinate a whole-of-government approach – including governors, state and local officials, and members of Congress – to develop the best options for safety, well-being, and health of the American people.”¹⁹² Bold and well-intentioned this mission may have been, however, in some nursing home administrators’ eyes, the reality did not stack up to the Task Force’s stated goals.

“There was a very big disconnect, because we are regulated by the federal government, as well as our own state regulations. Even to this day, there is a discrepancy between the two of them ... We were always shifting between: ‘What is the State’s requirements and what is the federal requirement?’ ... And then it was one CMS memo after another, after another, after another. It was hard to keep up with the data, so it was hard to keep up with their changes.”

– Nursing Home Administrator, Maricopa County, AZ

“Honestly, the [State] Department of Health is just as confused as everybody else. When they learned new things, we also learned new things. And we’re constantly updating our mitigation plan to reflect those changes and to be in compliance with the CDC and the Department of Health.”

– Nursing Home Administrator, LA County, CA

In May of 2020 – just three months into the COVID pandemic in the United States – *The New England Journal of Medicine* was already documenting cracks in the Coronavirus Task Force’s “whole-of-government” approach to coordination and communication across entities. “COVID-19 has exposed major weaknesses in the United States’ federalist system of public health governance, which divides powers among the federal, state, and local governments,” the author argued, “SARS-CoV-2 is exactly the type of infectious disease for which federal public health powers and emergencies were conceived: it is highly transmissible, crosses borders efficiently, and threatens our national infrastructure and economy ... Cases are mounting nationwide with appalling velocity. Strong, decisive national action is therefore imperative. Yet the federal response has been alarmingly slow to develop, fostering confusion about the nature of the virus and necessary steps to address it. States and localities have been at the leading edge of the response but have exercised their public health powers unevenly ... The lack of interjurisdictional coordination has and will cost lives.”¹⁹³

For its part, the federal government itself did not entirely disagree, stating in a June 2020 GAO report on COVID-19 response and recovery efforts that “in the midst of a nationwide emergency, clear and consistent communication – among all levels of government, with health care providers, and to the public – is key.”¹⁹⁴ They have found, however, that “uncoordinated communication from federal to state and local jurisdictions, and to providers and the general public, has contributed to confusion, frustration, and in some cases, individuals’ failure to seek or receive public health interventions” in the past.¹⁹⁵ One glaring example of this lack of coordination involved the failure to ensure that nursing homes receive sufficient life-saving

personal protective equipment (PPE). An NPR article points out that “despite President Trump’s pledge on April 30 to ‘deploy every resource and power that we have’ to protect older Americans,” by the end of May, 20 percent of the nation’s over 15,000 nursing homes reported that they had less than a week’s supply of masks, gowns, gloves, eye protectors, or hand sanitizer.¹⁹⁶ Furthermore, in early April 2020, CMS released guidance which essentially tasked States with the primary responsibility of implementing federally mandated protections and protocols regarding COVID-19. CMS pointed to “President’s Trump commitment to a COVID-19 response that is locally executed, state managed, and federally supported.”¹⁹⁷ Shifting the burden of implementation to the states, however, left governors scrambling and competing to obtain tests and PPE.¹⁹⁸

To be fair, the U.S. is not alone in the difficulties it faced around coordinating and communicating policies for long-term care facilities during the COVID pandemic. In its July briefing on *Preventing and Managing COVID-19 across Long-Term Care Services*, the World Health Organization acknowledges that in countries around the world, “governance of the long-term care system often involves multiple sectors, different ministries and different levels of government.”¹⁹⁹ Across the globe, these systemic challenges have led to a set of difficulties that also contributed to the nursing home crisis in the U.S., including “planning, oversight, and accountability;” creating a “coordinated response between long-term care and the health care sectors;” and enabling “effective resource allocation.”²⁰⁰

Not all nations were as burdened by these coordination challenges, however and moving forward, the United States can learn from what worked elsewhere. In Singapore, for example, the Agency for Integrated Care and the Ministry of Health jointly developed a COVID response plan with long-term care service providers. Rules and guidance around areas such as “infection control and prevention measures, access to PPE, distancing and zoning measures, suspension of visitors, alternative accommodation for long-term care workers, and testing” were centrally defined and rolled out across the sector. The Agency also created an incident response team to support long-term care providers facing COVID-19 outbreaks.²⁰¹ Australia experienced lower infection and death rates than many comparable OECD[§] countries, with just over 28,000 confirmed cases and 909 deaths as of January 15, 2021.²⁰² A McKinsey & Company report determined that in addition to Australia’s geographic advantage, the country’s success is also attributable to “strong collaboration between the public and private sectors” and that this collaboration is “transferable and repeatable elsewhere.”²⁰³ Rigorous and immediate action in South Korea was also buttressed by a coordinated approach, including – in February – shutting down nursing home visitation, implementing universal testing of residents and staff, and rolling out contract tracing for those exposed.²⁰⁴ A recent *Wall Street Journal* analysis found that “COVID Deaths as a Percent of Long-Term Care Beds” in Australia, Singapore and South Korea were 0.32%, 0.02% and 0.01% respectively, while the U.S. has performed significantly worse at 4.2%.²⁰⁵

One takeaway from examining these best practices from around the world is that coordination and communication are key.

[§] OECD stands for the Organisation for Economic Co-operation and Development. It focuses on European and Atlantic economic issues, along with creating policies that assist less developed countries. There are 37 member countries including the United States, United Kingdom, and Canada.

Policy Recommendation #1: Study other nations’ centralized communication structures and include long-term care advocates in the governing body.

WHO Policy Briefing Suggestions

Centralize Response and Include Nursing Homes at the Table

- Ensure a focal point to manage long-term care (with a special focus on long-term care users and providers) in the overarching COVID-19 governing body.
- Establish joint steering committees and information- and data-sharing systems between sectors and subnational policy levels to ensure a coordinated response.²⁰⁶

CONCLUSION

We began this report by asking: *How many deaths could have been avoided, and how many lives can be saved moving forward?* While we cannot identify precise numbers to answer these questions, we can identify specific lessons about what went wrong within our nation’s nursing homes as they faced the most existential health threat they have encountered in modern times.

The remedies are clear and actionable. Sweeping reforms are needed, swirling around issues of ownership, racial and ethnic disparities, and coordination between levels of government, among others. At the same time, more fundamental improvements – sometimes just below the surface – must be enacted to fill the cracks in the foundation upon which our nursing home industry stands. These include the need to define federal minimum nurse staffing levels, to increase wages for direct care workers, to establish “essential caregivers” for residents, and to strengthen enforcement of infection deficiencies, among others.

The policy recommendations offered in this report are an important start. Broad adaptation of the recommendations would lead to better care, better outcomes, and improved well-being for millions of vulnerable older Americans. But there are further lessons to be learned, and still much work to be done. It is up to us – those who have borne witness to the price of inaction – to insist on necessary change. The cost of not doing so will certainly be counted in lives ... the choice is ours.

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