ADVANCING EXCELLENCE
IN LONG-TERM CARE COLLABORATIVE

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Advancing Excellence in Long-Term Care Collaborative Open Letter to the Biden Administration

September 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Brooks-LaSure,

The Advancing Excellence in Long-Term Care Collaborative is a not-for-profit entity that creates a forum for organizations and individuals committed to the needs of long-term care residents and staff to discuss policies that affect these vulnerable populations. As a result of these discussions, and based on the varied and extensive experience of our membership, our board has developed the following recommendations for the Biden-Harris Administration to consider as critical priorities in post-acute and long-term care (PALTC) communities, such as nursing homes and assisted living communities.

COVID-19 and its variants will continue to impact our lives for the foreseeable future, and PALTC residents will continue to be affected by this and other infectious diseases. **Advancing Excellence welcomes the opportunity to work with the Biden-Harris Administration to ensure that emerging policies and regulations incorporate clinical, ethical, and operational considerations to help improve the lives of vulnerable residents and staff in PALTC during this pandemic and beyond**.

Sincerely,

Barbara Bowers, PhD, RN
Chair of the Board

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Advancing Excellence in Long-Term Care Collaborative

Organization Members

- American College of Health Care Administrators
- American Geriatrics Society
- American Health Care Association
- AMDA – The Society for Post-Acute and Long-Term Care Medicine
- American Association of Post-Acute Care Nursing
- American Society of Consultant Pharmacists
- Center for Aging Research and Education, School of Nursing, University of Wisconsin-Madison
- Gerontological Advanced Practice Nurses Association
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- National Association of Health Care Assistants
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ADVANCING EXCELLENCE
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Recommendations to the Biden Administration for Improving Nursing Homes in the Pandemic and Beyond

Overview

Our nation has spent well over a year fighting COVID-19. During this time, the people working and living in long-term care settings have disproportionately suffered from the pandemic.[i] This is reflected in the high number of deaths, lack of availability of enough caregiving staff, and delayed access to personal protective equipment (PPE) for nursing homes. The vaccination program has gained some traction—with the majority of people living in nursing homes and assisted living communities protected. However, staff vaccination and vaccine mandates still present challenges, and other aspects of long-term care would benefit from closer attention, including longstanding issues the pandemic unmasked.

Recommendations to the Biden Administration for Improving Nursing Homes in the Pandemic and Beyond

Executive Summary

The **Advancing Excellence in Long-Term Care Collaborative** has developed the following policy recommendations for the Centers for Medicare and Medicaid Services (CMS) and other government agencies to support nursing home residents and their families along with nursing home staff during the pandemic and beyond.

1. **Coordinate the pandemic response across agencies.** Align public health and regulatory guidance (including across agencies) to alleviate confusion and provide PALTC organizations with consistent, actionable information related to staffing, personal protective equipment (PPE), testing, vaccines, and therapeutics.

2. **Improve infection control**. Develop and implement a federal regulatory framework that addresses the root causes of performance gaps related to infection prevention and control in PALTC settings of care.

3. **Ensure guidance reflects person-centered care principles**. Issue cohesive guidance for senior communities that includes cultural competence and rights of persons of color to safely normalize social activities in nursing homes. Create a framework for how person-centered care principles will be incorporated in future pandemic planning.

4. **Create incentives to support staff stability.** Reward and support facilities that meet certain compensation, benefits, and training thresholds. Develop educational criteria and establish funding for training programs.

5. **Create an initiative to support nursing homes with QAPI.** Authorize the use of CMP funds to create special units to assist nursing homes with quality assurance and performance improvement (QAPI) beyond regulatory requirements.

6. **Create viable value-based payment mechanisms.** Design payment structures that support both post-acute and long-term care and incentivize high quality. Revive discussions about a federal public option for long-term care insurance.

The following sections elaborate on each of these recommendations designed to improve care and outcomes for the 1.2 million nursing home residents[ii] and residents of other types of PALTC communities.

1. Coordinate the pandemic response across agencies

Problem

The COVID-19 pandemic has not only exposed the deep systemic flaws in how we care for older adults in the U.S., it has also highlighted and aggravated the degree to which the federal agencies responsible for supporting and overseeing nursing homes do not coordinate their work. This has created confusing and even conflicting guidance; disparities in access to critical information, support, and resources; and inconsistency in data reporting.

Recommendation

Evaluate the federal response to COVID-19 to implement a better-coordinated, cross-agency federal "care model" for PALTC during a public health emergency. Promote fair and equitable access to staffing, PPE, testing, vaccines, and therapeutics. Align public health and regulatory guidance to provide nursing homes with clear, specific, actionable, and appropriate direction to keep residents, families, and staff as safe as possible.

Background

The SARS-CoV-2 viral pandemic first appeared in U.S. nursing homes in February 2020. While little was known about the virus at that time, it was clear that nursing homes and other PALTC settings were uniquely vulnerable environments for viral spread. Robust infection prevention and control was urgently needed, both to keep the virus out of buildings, and to control its spread once it was inside a nursing home. This required, at a minimum, that nursing homes across the country be prioritized for access to PPE, testing, and surge staffing. Communicating best practices in isolating, cohorting, and quarantining was also needed, as was an understanding of the connection between community positivity and nursing home outbreaks.

Sadly, none of this vital support was provided at the federal level, leaving states, localities, and even individual nursing homes to develop their own highly variable approaches—or none at all. To mitigate the lack of federal support, some states formed compacts to gain access to testing and PPE supplies.[iii,iv] Other states competed with each other[v] as market conditions made the prices for these resources soar, with little federal regulation for unethical practices. Despite their vulnerability, nursing homes, assisted living communities, and other PALTC settings were often left out of state-led efforts. States issued a flurry of executive orders and mandates, rarely with the benefit of any PALTC expertise at the table.[vi] New York offers a well-publicized example of some of the challenges that states have experienced responding to the pandemic.

Lack of coordination at the federal level, and lack of PALTC representation at both the state and federal levels, had tragic consequences. The residents and staff of long-term care settings have been disproportionately impacted by COVID-19, with 130,296 nursing home resident and 1,625 staff deaths directly attributable to COVID-19 as of March 7, 2021.[vii] This number is widely felt to be under-reported, in areas like New York by as much as 50%.[viii] This high rate of illness, suffering, and death in nursing homes could have been mitigated with proper planning, coordination, and resources.

In summer 2020, the Trump White House convened the independent Coronavirus Commission for Safety and Quality in Nursing Homes.[ix] The Commission's work culminated in September 2020 with the release of a report cataloguing 27 recommendations and associated action steps. While some of the recommendations were considered common sense, many stakeholders argued that they did not go far enough towards addressing systemic problems that pre-dated COVID-19.[x] Additionally, the Commission itself had no authority to act on its findings, and the Trump Administration asserted the report offered validation of their approach, taking minimal action to implement the recommendations.[xi]

Specific Strategies:

- **Create a federal cross-agency taskforce to evaluate the current care model.** Building on the Commission report, evaluate the federal response to the COVID-19 pandemic in order to develop and implement an action plan for reform broadly applicable to PALTC support and oversight going forward.

- **Execute a coordinated federal response to ensure consistent access to critical resources.** For the duration of the public health emergency, establish efficient processes to ensure that PALTC facilities have ongoing, reliable access to vaccines, testing, PPE, therapeutics, relief funding, and surge staffing. This could include a single "point of truth" source of guidance that all agencies reference.

- **Align guidance and regulations; ensure applicability to nursing homes.** Include PALTC clinical and practical operations expertise in this agency-wide effort and integrate guidance from the Centers for Disease Control and Prevention (CDC), Centers for Medicare & Medicaid Services (CMS), Food and Drug Administration (FDA), Occupational Safety and Health Administration (OSHA), and other relevant agencies to ensure a consistent, comprehensive response to the pandemic—from prevention and control, through diagnosis, treatment, and visitation.

- **Create parity between regulations and recommendations for nursing homes and other care settings.** Before implementing a new policy or regulation for nursing homes, assess whether it would also be beneficial to other acute, post-acute, and long-term care settings. Coordinate to ensure that nursing homes are not the only settings targeted for enforcement of these policies or regulations.

2. Improve infection control

Problem

The COVID-19 pandemic has brought greatly heightened public awareness to a 30-year challenge with poor infection prevention and control (IPC) in nursing homes.

Recommendation

Develop and implement a federal regulatory framework that addresses the root causes of IPC performance gaps in PALTC settings of care. Ensure that this set of requirements incentivizes nursing home organizations to improve the key elements of 1) staffing; 2) building design, construction, renovation, and systems upgrades; 3) financial models, funding, and resources dedicated to supporting excellence in IPC; and 4) a pre-regulatory consultative process that identifies and mitigates IPC gaps before state or federal surveys occur.

Background

The challenge of having excellent IPC in nursing homes (and across all PALTC settings) is exacerbated by multiple factors[xii] that are well understood by nursing home operators and other members of Advancing Excellence:

- **Population**
  - A frail and medically complex resident and patient population

- **Clinical staff**
  - Insufficient staffing, requiring caregiving staff to rush normal IPC procedures
  - Staff who go between rooms and/or between buildings, live in the greater community, and often work two or three jobs to make a living (see Recommendation 4 below)
  - Inconsistent and minimal training in IPC across all staff, both clinical and non-clinical; no dedicated, paid time for regular in-service training
  - Disengaged medical directors
  - No single individual being responsible for IPC in the setting of care (i.e., a dedicated infection preventionist)

- **Buildings**
  - Often two, three, or four residents to a single room
  - Older buildings without upgraded HVAC systems for frequent air exchanges, treatment, and filtration
  - Buildings not designed for isolation, quarantine, and/or cohorting
  - Environmental services staff not trained in the important role of environmental services in IPC

- **Financial Models, Funding, and Resources**
    - Complex financial models that can be deliberately opaque and "bury" profits that could be applied to better patient care, especially IPC
    - Inadequate access to IPC supplies such as gowns, gloves, masks, and face shields
    - Inadequate surveillance systems for ongoing data collection on infections using written nursing-home-appropriate infection definitions
    - Inadequate or inconsistent access to testing for both surveillance and diagnosis of cases and outbreaks
    - Poor communication and understanding of test results and how to respond to them
    - Inadequate and inconsistent access to therapeutics and vaccines for both residents and staff

- **Survey and Regulatory**
    - A survey process that is punitive and demoralizing, has not addressed the systemic or underlying causes of IPC deficiencies, and has not achieved significant improvements in IPC deficiencies.

SARS-CoV-2 is a highly transmissible virus, spreading asymptomatically through airborne (aerosol and droplet) means through an immunocompromised patient population, making the nursing home a particularly perilous environment for outbreak management.[xiii] Smaller, more autonomous residences and availability of private rooms with bathrooms have been linked to both better quality of life (see Recommendation 3) and better infection control. During the pandemic, Green House homes and other small nursing home models with private rooms and bathrooms reported both lower COVID-19 case rates and deaths than more traditional nursing homes.[xiv]

Other dangerous bacterial, viral, and fungal pathogens are also found in nursing homes and congregate settings of care in PALTC, including seasonal influenza, pneumonia, extensively drug-resistant tuberculosis (XDR-TB), C difficile (c-diff), norovirus, methicillin-resistant Staphylococcus aureus (MRSA), carbapenem-resistant Enterobacteriaceae (CRE), Vancomycin-Resistant Enterococcus (VRE), and candida auris, among others, with an increasing number being multi-drug resistant.[xv]

Nursing home residents' medical complexity and frailty is further complicated by a very heavy medication regimen; residents often are on 15 or more drugs every day.[xvi,xvii] Antibiotics are routinely overprescribed, leading to greater drug resistance.[14] Medication optimization procedures (deprescribing, gradual dose reduction, non-pharmacologic alternatives, etc.) are poorly understood or deployed.

Finally, the nursing home survey/inspection system levies many millions of dollars in fines (civil money penalties or CMP) every year. The intent is to apply CMP funds to improve nursing home quality, but these funds are tied up in complex administrative procedures and go unspent, when instead they could be deployed to solve IPC challenges in nursing homes.

Specific Strategies

Engage CMS to review regulatory requirements and guidance to create provisions for improving the following factors that impact IPC. Offer funding, incentives, and resources to help nursing homes meet any new requirements. Many of these strategies are further described in the other recommendations.

- **Staff**
  - Improve medical director engagement. Despite the federal requirement for every nursing home to have a physician medical director,[xviii] there is no adequate mechanism to enforce this requirement. The Advancing Excellence in Long-Term Care Collaborative wrote to CMS in September 2018,[xix] describing the many ways in which medical directors are not used for the purpose for which the OBRA 1987 law was enacted, i.e. to provide quality oversight in the nursing home. One small step the federal government can take is to establish a national registry of nursing home medical directors, showing the specialty of these physicians and what nursing homes they support. Another would be to require a minimum level of training for medical directors in order to carry out the many and complex responsibilities of the role.
  - Update guidance to ensure that every nursing home has a dedicated infection preventionist, responsible for developing and implementing IPC policies, surveillance and data collection, outbreak management, staff training, and oversight of proper IPC procedures in the home.
  - Direct facilities to provide comprehensive, regular IPC training to all staff—not simply clinical staff—that would include: environmental services, housekeeping, dietary, activities, administrative, etc.
  - Provide funding to support paid time for staff to go through this training and require that nursing homes certify that the training has been completed.
  - Ensure that staffing levels and competencies are aligned with the needs of the residents and patients (see Recommendation 4).
  - Provide incentives for nursing homes to adequately compensate CNAs so that they are not forced to take on 2nd and 3rd jobs; provide a benefit structure and a career path (see Recommendation 4).

- **Building**
  - Direct facilities and provide funding to ensure that nursing homes have upgraded physical-plant systems to improve ventilation and HVAC. This will allow for isolation rooms, quarantine areas, and cohorting.
  - Offer incentives to convert nursing homes to all single-occupancy rooms.

➢ Financial Models, Funding, and Resources

- Offer funding and support to integrate a robust infection surveillance data system into existing nursing home data collection.
- Collaborate with other federal and state agencies to ensure that all nursing homes have access to an adequate supply of PPE, and are prioritized for access to testing, therapeutics, and inoculations as the needs dictate (see Recommendation 1).
- Require greater transparency in ownership structures and business models. Reduce or eliminate the ability of owners to hide, bury, or divert funds that should go to patient care enhancements such as IPC improvements.
- Liberate millions of dollars of civil monetary penalty (CMP) funds from bureaucratic complexity; specifically prioritize these funds for IPC improvements (see Recommendation 5).

➢ Survey and Regulatory

- Develop a pre-survey consultative support system that can move a nursing home into greater compliance with CMS nursing home regulatory requirements; consider deploying QIN/QIOs more effectively for this (see Recommendation 5).
- Create a regulatory/enforcement environment that does not punish a nursing home for gathering data and reporting possible deficiencies; only for hiding or not reporting these.
- Consider establishing a Centers of Excellence in Infection Control program for nursing homes.

3. Ensure guidance reflects person-centered care principles

Problem

Despite prior attempts to prioritize person-centered care principles in the PALTC industry, the COVID-19 pandemic elevated paternalistic "protective measures" that rolled back progress in allowing nursing home residents person-centered care and autonomy. The experience of "quality of life" for people living in long-term-care communities was reduced to whether or not residents caught the virus.

Recommendation

Issue cohesive guidance to safely normalize social and communal activities in nursing homes/PALTC communities. Create a framework for how person-centered care principles will be measured and enforced going forward.

Background

Person-centered care is "respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions."[xx] Person-centered care is especially important for nursing home residents because a majority of people who are admitted to nursing homes will spend the rest of their lives there.[xxi] But, in spite of recent movements and initiatives to promote person-centered care in nursing homes, medically-focused, paternalistic models of care have persisted.

The effort to implement appropriate infection control practices during the COVID-19 pandemic largely abandoned person-centered care principles. **People who live in nursing homes have been more severely restricted than any other group in the United States.** Federal guidance to restrict communal activities and visitation to mitigate infections has led to significant social isolation, which has had devastating consequences for resident health and well- being.[xxii,xxiii] Social isolation and exclusion have been associated with increased risk of premature death and dementia along with accelerated disease progression.[xxiv]

The impact is even more severe for the 50% of residents in nursing homes who have cognitive impairment. [xxv] People with dementia are two times more likely to contract, and four times more likely to die from, COVID-19; these rates are even higher among Black people with dementia.[xxvi] People with dementia are already at high risk for loneliness which is exacerbated by COVID19 restrictions. Additionally, for residents with cognitive impairments, the use of masks is not simply a nuisance, but can have significant detrimental impact on the ability to communicate (also true for residents with hearing impairments), with a devastating impact on well-being.[xxvii] The CDC has, in fact, reported 1,000 excess deaths per week during COVID-19 among people with dementia compared with the expected death rates projected from previous years.[xxviii]

In light of these negative impacts, it is critical that resident quality of life and relationships are factored into public health recommendations. The most current guidance from CDC (released in April 2021) provides parameters for allowing more visitation in nursing homes, as well as precautions for close contact between vaccinated people.[xxix] However, the guidance does not provide a path forward for further de-escalation of social distancing and discontinuing the use of face masks by the caregivers who are interacting with residents based on vaccination status. For example, when will it be acceptable for vaccinated employees to care for vaccinated residents without masks? Is there a path forward that could link staff and resident vaccination thresholds and community outbreak status with allowing all staff and residents to unmask and discontinue social distancing?

As the Biden Administration moves forward in responding to the PALTC COVID-19 crisis, person-centered principles of care should be front and center. Urgent action must establish a path towards safe socialization for people in PALTC settings and near the end of their lives. Allowing smiles, hugs and kisses is a good start, but enforcing nursing home practices that empower residents to make decisions about their daily lives will help transform future nursing homes from places of isolation during a pandemic into places where residents can live a meaningful life.

Specific Strategies

- **Update guidance for residents, visitors, and staff members.** Convene a multi-stakeholder panel including infection prevention professionals, person-centered care advocates, residents, family members, and PALTC professionals to review and refine guidance to normalize visitation and intra-nursing home socialization.
    - The panel should review current guidance for conflicting statements and ambiguity. Removing these statements may make it less likely that nursing homes will take the most restrictive interpretation of guidance to the detriment of residents.
    - Modify existing guidance to develop a path toward normalization of visitation, group activities, and care interactions for both vaccinated and unvaccinated residents, staff, and visitors. Expand the guidance on the frequency and number of visitors in relation to the population density within each building. Updated guidance should also address circumstances under which it is acceptable to:
        - Discontinue mask-wearing for *all* residents and staff regardless of vaccination status
        - Resume non-distanced, unmasked group activities among residents, including a plan for allowing such for those who are not vaccinated
        - Allow visitors to have close physical contact, visit unscheduled, and spend time with residents in their private or shared rooms, including with residents who have not been vaccinated

- Develop a nursing home risk assessment tool that can help guide nursing homes in the development of visitation, isolation, and other pandemic-related policies.
- Review the role and status of activities professionals during restricted visitation. These personnel are essential to meeting residents' psychosocial needs, especially when social interactions are limited.

- **Provide clear guidance to surveyors.** Ensure that good-faith efforts to allow appropriate visits do not result in citations or civil monetary penalties. Establish expectations for surveyors to follow the same guidelines as employees in long-term care for testing and/or vaccination.

- **Review regulatory barriers to person-centered care.** Engage the cross-agency taskforce described in our first recommendation to review regulations to assess implications for person-centered care and develop a plan to modify regulations that may have the unintended consequence of reinforcing the traditional medical model to the detriment of resident rights and person-centered care.

- **Fund development of quality measures to capture the concept of person-centered care.** Review prior and current measurement efforts and make plans to implement new and existing measures in quality programs like the Five Star Quality Rating System and payment programs like the Skilled Nursing Facility Value-based Purchasing program.
    - Involve PALTC professionals, residents, and families in measure development and program design
    - Some key person-centered measurement concepts for nursing homes could include:
        - Resident- and family-reported performance measures created from resident and family surveys to capture topics like self-determination/autonomy, privacy, dignity, meeting social needs, meaningful activities, shared decision-making, and care alignment with resident goals.
        - Measures of nursing home processes or infrastructure tied to person-centered care such as consistent assignment, single occupancy rooms or household models (See Recommendation 1), flexible mealtimes, and others selected in collaboration with residents and families.
        - Measures such as family visits per resident in person or via telehealth. These could be stratified by race, gender, location, or socioeconomic status to capture disparities in performance on these measures during the pandemic.

4. Create incentives to support staff stability

Problem

Many adults with significant disabilities, functional dependencies, or needs related to the management of chronic conditions or co-morbidities can remain at home if sufficient services and supports are available. However, many others require the support found only in nursing homes. The current crisis in recruiting and retaining sufficient numbers of nurses, advanced practice nurses, and Certified Nursing Assistants (CNAs) who have demonstrated core competencies is jeopardizing quality of life, quality of care, and clinical outcomes for nursing home residents. The COVID-19 pandemic has exacerbated this crisis, further putting this vulnerable population at risk. The relationship between staff and leadership may also have contributed to lagging vaccination rates among nursing home staff.

Recommendation

Reward and support nursing homes that meet certain compensation, benefits, training, and staff retention thresholds. Develop educational criteria and establish funding for training programs.

Background

The complexity and dependency levels of long-term care residents have increased dramatically in recent years because of an older population and earlier hospital discharge policies.[xxx] Long-term nursing home residents have higher levels of activities of daily living dependency (a global measure of physical and cognitive impairments), and an increasing percentage of residents have dementia.[xxxi] These changes in resident characteristics require a corresponding change in the level of staff skill and knowledge, and necessitate robust continuing education programs. Recruiting experienced staff, providing them access to the education to do their jobs well, and offering the wages, resources and culture needed for retention are essential for meeting residents' evolving needs, especially in the pandemic environment.

Nationally, the average annual turnover is 80% for CNAs in long-term care settings, while nurse turnover averages exceed 50%.[xxxii,xxxiii] Recruiting nurses and CNAs to replace those who have left is increasingly difficult, requiring costly marketing and staff replacement programs and resulting in frequent periods of understaffing. [xxxiv] Advancing Excellence members and researchers have also shared growing challenges with turnover among nursing home administrators and other leaders that will need to be addressed.[xxxv,xxxvi]

In addition to resident quality of life and the quality of care being jeopardized by frequent turnover and insufficient staffing[xxxvii], clinical outcomes are also negatively impacted:

- **Quality of life** is negatively affected through delays in care (increased waiting time) and the inability of staff to provide care that is responsive to residents' preferences. Turnover also disrupts the relationships between staff and residents that are fundamental to resident quality of life.[xxxviii]

- **Quality of care** is undermined by the loss of knowledge about care delivery, specific care processes and culture, and the nuances of individual resident care needs. The ability to identify early change in resident health condition relies, in part, on staff members' intimate personal knowledge of residents, something that is gained over time and lost with frequent staff turnover.

- **Poor clinical outcomes** have also been linked to high levels of nurse turnover, including a direct link to increased hospitalization rates.[xxxix] Failure to identify early change in condition is closely associated with increased hospitalization, poorer outcomes, and increased cost.[xl] The situation has become more dire during the COVID-19 pandemic. Higher rates of staff turnover were already linked to greater likelihood of infection control citations.[xli] Additionally, many CNAs work in more than one nursing home, and moving from one care setting to another was likely a significant source of virus spread.[xlii]

The nursing home staffing crisis has a variety of causes related to the experiences of both nurses and CNAs. The pandemic has highlighted and exacerbated this situation.

Compared to hospital nurses, nurses working in long-term care settings have lower wages, fewer resources, and fewer training opportunities.[xliii,xliv] Registered nurses in long-term care experience significant wage disparity (86%) compared to those with similar credentials working in acute care settings.[36] During the pandemic, insufficient access to resources was clearly illustrated by the long delays in acquiring PPE for nursing home staff across the U.S.—including from the Federal Emergency Management Agency (FEMA)—leaving both staff and residents unprotected.[xlv] Nurses working in long-term care also frequently lack access to high quality training programs, such as residency programs for new RNs or LPNs. Because working in a nursing home compares so unfavorably to working in a hospital, this contributes to challenges recruiting and retaining advanced practice nurses, RNs, and LPNs.[xlvi]

CNAs have emerged from the COVID-19 pandemic as the "unsung heroes" of long-term care despite earning near poverty level wages. One in three CNAs qualify for public benefits[xlvii], and 42% of CNAs are without health insurance, often due to inability to afford the employee portion of plans offered by their employers.[45] Efforts to recruit and retain qualified CNAs are also undermined by poor working conditions, lack of advancement opportunities, insufficient training for the work, and a lack of culture that values and explicitly acknowledges their work.

Recruitment and retention efforts are also undermined by stigmas associated with caring for older adults and common perceptions that nursing homes are undesirable places to live and work.[xlviii] Stigmas may be an especially powerful deterrent for students who believe working in this environment is less prestigious than working in acute care.

Specific Strategies

- **Offer incentives, or directly support increased wages.** Promote wage parity with hospital and other post-acute care settings for skilled nursing staff, including CNAs, through wage pass throughs, state pay for performance programs, and other incentives. Any increased reimbursement should include clear guidance and transparency on direct wage increases for CNAs and nurses. Increasing compensation may help nurses and CNAs overcome stigmas associated with working in the nursing home setting.
- **Consider including an element related to environment and workplace quality in a nursing home quality program.** Recommend a minimum level of health insurance benefits offered by long-term care employers. Research current coverage rates including staff eligible for health insurance benefits, skilled staff enrolling in employer-provided health insurance programs, staff who decline and the reasons for declining, and the proportion of staff without individual and family health insurance coverage. Identify coverage barriers and develop programs to increase coverage among nursing home staff.
- **Develop educational criteria.** Create an ongoing task force to periodically review and update recommendations for educational content and modes of delivery for nursing home staff development. These modules should incorporate person-centered care principles. Develop competency-based professional leveling criteria for staff. Promote opportunities for continuing education that align with patient acuities and person-centered care principles to facilitate professional growth and expertise development. Encourage nursing homes to acknowledge professional development and achievement of added competencies through internal advancement ladders (or clinical ladders[xlix]) and increased compensation.
- **Use CMP funds to support training programs.** Evaluate the alignment between available training programs and the training needs of skilled nursing staff, including CNAs. Build upon the CMS-CDC Fundamentals of COVID-19 Prevention for Nursing Home Management trainings by focusing on topics including health equity.[l] Encourage use of CMP funds and cross-state collaboration on the development of accessible, relevant continuing education for staff at all levels. Using these funds, states should work collaboratively on the development and implementation of training programs to fill gaps between training needs and training completed.
- **Incentivize meeting training thresholds.** Establish training thresholds and develop a mechanism to tie these thresholds to reimbursement increases. Include meeting training thresholds in survey criteria.

5. Create an initiative to support nursing homes with QAPI

Problem

Notwithstanding several efforts over the years to improve quality of care and life in nursing homes via traditional quality improvement methods, the overwhelming philosophical push in nursing homes is still to achieve regulatory compliance with federal requirements. Failure to comply with federal regulations means threat of punishment via termination of Medicare and Medicaid funding, civil money penalties, directed plans of correction, etc. The punitive nature of the regulatory process was evident in the recent COVID crisis. Instead of being helped to deal with the pandemic, nursing homes were criticized and blamed for misdeeds and failures. The Administration should act now to prevent another crisis of equal or even greater magnitude.

Recommendation

Authorize the use of CMP funds to create a function within each state survey agency to assist nursing homes with quality assurance and performance improvement (QAPI). The QAPI process should be separate and distinct from the federal regulatory process.

Background

Nursing homes began as alms and poor houses and gradually evolved into an alternative to family care, paid for primarily with public funds. As problems emerged in the nursing home, so did public outcry; leading to a rigid and inflexible regulatory structure that assumes the worst and seeks to improve quality through punishment and chastisement.

The Nursing Home Reform Law, which was part of the Omnibus Reconciliation Act of 1987 (OBRA 87), implemented in the 1990's, led to sweeping changes in regulation and enforcement including a rigorous survey process based on regulatory requirements.[li,lii] Although it did improve baseline nursing home performance, this punitive approach to quality improvement has proved limiting over time. Subsequent regulations continually stacked on top of OBRA 87 compound the challenges associated with compliance to the point that nursing homes must all too often focus on avoiding negative consequences, rather than proactively improving quality of care and resident and family experiences.

While the Affordable Care Act mandated internal, proactive Quality Assurance and Performance Improvement (QAPI) in all nursing homes[liii], a lack of guidance and support from governing bodies has led to disappointing results and the requirement to establish these QAPI programs was never fully implemented. Governing bodies have focused on regulation, compliance, and remedy rather than improvement, quality, and creation of appropriate and state-of-the art living environments for our elderly. This, of course, leads to nursing homes focusing there as well, rather than on QAPI.

The Culture Change Movement, Quality Improvement Organization (QIO) Scopes of Work, and other efforts have made some progress, encouraging nursing homes with positive reinforcement to improve quality of care and life. But, as evidenced by the COVID experience, nursing homes remain challenged to proactively face current and future challenges.

Specific Strategies

CMS should recognize and support the needs of nursing homes to improve outside of the regulatory process, by initiating a process in each state to support nursing homes with QAPI. There is precedence for this activity as evidenced by programs such as the Advancing Excellence in America's Nursing Homes Campaign, Quality First, the QIO Program, and several statewide programs including those in Maryland and Washington.[liv] Funding for this effort could be provided by using Civil Money Penalty (CMP) funds which have amassed to an estimated 400 million dollars.[lv] With preparation and planning, this effort can be provided by state surveyors in the State Survey Agency who are knowledgeable and aware of best practices and have a relationship with the nursing homes. A cautionary note is that these efforts must be kept separate and distinct from the current federal regulatory process to ensure they are collaborative and productive as opposed to punitive.

Key steps in establishing this process include the following:

- **Convene an expert panel of stakeholders to design the QAPI initiative.** Include national association representatives, providers, regulators, advocates, nursing home residents and families, QIOs, and representatives from states that created QAPI programs that have worked to improve care in nursing homes.

- Review the evidence to **learn from effective QAPI models for nursing homes** in various markets.

- Investigate the possibility of **creating a consultative unit within the State Survey Agency** that is separate and distinct from the federal regulatory process.

- Identify the amount of CMP funding that is available state-by-state and authorize the CMS Regional Offices **to approve use of CMP funds for QAPI** and/or consultative services by the State Survey Agency.

6. Create viable value-based payment mechanisms

Problem

The current nursing home payment methodology sets up two classes of residents and care: long-term care that is often underfunded by Medicaid, and post-acute care that has a higher reimbursement by Medicare and is often used to offset long-term care losses. Most payment is still considered "fee-for-service" rather than rewarding high quality care and resident outcomes via value-based payment or pay for performance. The COVID-19 pandemic has heightened funding challenges—especially for under-resourced homes with many long-term care residents—and exposed pre-existing pressures.

Recommendation

Convene a multi-stakeholder group to evaluate payment methodology and create a viable value-based payment mechanism to support both post-acute and long-term care for both Medicare and Medicaid residents. Revive discussions about creating a federal option for long-term care insurance.

Background

The long-term care industry is at a critical inflection point as care-delivery and funding challenges and pressures are impacting already razor-thin operating margins for providers. As the nation faces growing aging demographics and the potential substantial increase of people in need of access to long-term care services, we should review the impact of COVID-19 on long-term care payment, increased acuity, and the structure of nursing homes and other long-term care communities.

There are two primary payment sources in long-term care: Medicaid and Medicare. Medicaid, the primary payer for more than 60 percent of all nursing home residents, falls markedly short of covering the cost of caring for these residents—leaving nursing homes dependent on Medicare payments to cover this 20-30% deficit.[lvi] Medicare, on the other hand, provides higher payment for enhanced care and services during the short-term rehabilitation stays, but many of these residents will remain in the nursing home and convert back to Medicaid as their primary funding source.

Most beneficiaries only qualify for Medicare benefit coverage for a few weeks before reverting to their primary coverage, typically Medicaid and/or out-of-pocket, for any further care that is needed.[54] Only 11% of seniors carry long-term care insurance to help with out-of-pocket expenses.[lvii] Because of this gap in coverage, stakeholders have discussed both federal and state-based programs for covering long-term services and supports.

Current programs such as Medicare and Medicaid need to fundamentally change to effectively meet the needs of our aging population. As the demand for long-term care increases, so does the need to design payment models that will enable providers to continue to deliver high quality care to the aging population of our nation.

Value-based payment models may help shift this paradigm and incentivize high quality care in the long-term. The first nationwide Medicare value-based payment program for nursing homes, the Skilled Nursing Facility Value-Based Purchasing Program, was implemented for fiscal year 2019 with one measure of quality: hospital readmissions.[lviii] A related demonstration program did not find that the program reduced costs or improved quality[lix], but results for state programs have been more favorable. At least eight states have implemented Medicaid pay for performance programs, and research has shown that these models can lead to modest improvements in quality outcomes, but that program design is critical for fostering better care and avoiding unintended consequences.[lx,lxi,lxii] These findings underscore both the potential for value-based payment to drive improvement and the importance of careful program design involving a variety of PALTC stakeholders.

Advancing Excellence recommends a collaborative approach in redesigning the payment model to efficiently optimize resident health outcomes, resident and staff experience, and cost of care building upon work that has already been started in this area. This includes establishing value-based payment mechanisms and improving Medicaid reimbursement rates to, at a minimum, align with the overall cost of care for seniors, while leveraging opportunities for citizens to prepare for future needs through public insurance programs such as long-term care insurance.

Specific Strategies

- **Consolidate and review existing data.** Immediately convene a multi-stakeholder group including members of the Administration, provider leaders, professional health care association leaders, the Medicare Payment Advisory Commission (MedPAC), payers, and other key stakeholders to collaborate with appropriate agencies already involved in this work to review current Medicare and Medicaid post-acute and long-term care payment policies and collectively provide recommendations for payment reform.

- **Make long-term care insurance accessible and encourage participation by creating a federal public option.** A few models are available for review. These programs are designed to help with many medical, personal, and social services needed by individuals with disabilities or prolonged illnesses.
    - For example, Congress enacted the Community Living Assistance Services and Supports (CLASS) Act as part of the Affordable Care Act, to enable citizens to purchase federally administered long-term care insurance. While the CLASS Act was repealed due to questions about consumer adoption and sustainability, lessons may be available to inform the development of a viable, new program.[lxiii]

- Another example can be found in the State of Washington's public long-term care insurance program. Instituted in 2019, the program is funded through payroll deductions, similar to Social Security and Medicare, and will provide a lifetime benefit to those who meet the eligibility requirements.[lxiv]

- **Develop more appropriate Value Based Payment (VBP) programs for the post-acute/long-term care population.** Engage PALTC stakeholders in designing payment models that streamline cost-effective, quality care delivery. Advancing Excellence recommends using the following as a starting point, based on prior convenings on this topic:[lxv]
    - Develop more inclusive VBP programs that have explicit roles or tracks for nursing homes and address the PALTC populations.
    - Balance incentives to reduce costs at the expense of access and quality by building in risk adjustment, relevant quality measures, and other incentives.
    - Move from payer- to patient-focused definitions of "value" by including residents and families in the development of measures and programs.
    - Minimize provider burden through aligned requirements and resource support.

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