



Senate Finance Committee

A National Tragedy: COVID-19 in the Nation's Nursing Homes

March 17, 2021

LeadingAge's Statement for the Record

Thank you for the opportunity to comment on the above hearing. Our members and the older adults they serve have been irrevocably affected by this pandemic. We appreciate the concern that this Committee has expressed over the past year and its efforts to address the significant challenges posed by both public and private responses to the public health emergency.

LeadingAge is a tax-exempt national organization focused on education, advocacy, and applied research. The mission of LeadingAge is to be the trusted voice for aging. Our 5,000+ not-for-profit members include the entire field of aging services providers - nursing homes, home care and hospice, affordable housing, life plan/continuing care communities and assisted living.

We begin our statement by asking the most difficult question, what happened?

If only it were easy – if only there was an answer to the question, what happened? Why did so many people die in nursing homes? What magic bullet could we have fired to prevent this? What magic bullet can or should we look to in the future?

As Dr. Tamara Konezka testified, based on her rigorous, highly respected research, “the two strongest and most consistent predictors of worse COVID-19 outcomes are nursing home size, with larger facilities being more at risk, and COVID-19 prevalence in the surrounding community,” as opposed to star rating, staffing, access to PPE, etc.¹ The greater the presence of the disease in the community, the greater the impact on residents and staff. The second condition is something that we have tolerated for many years – large poorly funded nursing homes with many residents, many of the long-stay residents poor and racial minorities, again, at greater risk for this disease for all the reasons that we know as we attempt to address the impact of centuries of discrimination. In those communities with the highest spread, where staff are as affected as residents, the disease was at its deadliest.

When Dr. Konezka was asked, what could have been done to reduce this tragedy, she responded, better use of public health to control spread in the community. We needed a fast, all of government public health response to contain and control the disease and that did not happen.

¹ We appreciate that there is research showing that nonprofit nursing homes and nursing homes with higher rankings, many of whom are our members, fared better. However, they too faced all the public health challenges we discuss, herein, and without addressing those challenges, we consign all nursing homes, even the best performers, to an intolerable situation.

This pandemic was a failure of our public health infrastructure, and that failure trickled down to infect all the public and private health care and housing entities that supported at risk populations, both residents and staff.²

The underlying challenge to this disease – its very newness – was faced by all our members. It is called the novel coronavirus for a reason. Each day brought new knowledge about the disease, but that means that the day before, we were operating on old and not necessarily accurate information. For example, during the early days when the pandemic was new -- March and April 2020 -- a lack of understanding of how the disease spread resulted in inconsistent and often changing advice (e.g., when to use masks; testing limited to symptomatic staff and residents, before we realized it was spread asymptotically and was not contained; inconsistent directives from state, local and federal public health authorities).

In addition, the entire health care system was left to fight it out for essential supplies rather than having a centralized source (indeed, even FEMA couldn't adequately fulfill the White House's April directive to send 2 weeks of supplies to nursing homes months into the pandemic.)

Failure of public leadership to understand the disease led to new problems placed at the feet of nursing homes trying to follow the ever-changing directives. – e.g., closing down nursing homes to visitors saved lives (because of asymptomatic carriers, speed with which older persons died from infection) but because we had NO idea how long the crisis would last, created its own secondary health crisis, isolation.

Why is it so important to stress the public health failures? Because we must learn the right lessons if we are not going to repeat this disaster as this public health emergency continues and we also examine how to avoid future disasters.

To fix public health infrastructure in the future we must have:

- **Transparency and honesty;** credibility of public and private systems can only be built on a foundation of transparency and open communication, even but perhaps most importantly when we do not have answers.
- **National public reporting system** to ensure accuracy and consistency, including reporting of race, ethnicity, gender and age.³

² We note that the negative impact of the pandemic on older persons and persons living in nursing homes and other congregate settings, along with public and private response, is not limited to the United States. A survey conducted by Global Ageing Network, representing aging services providers throughout the world, revealed eerily similar experiences. <https://globalageing.org/gan-covid-report/>

³ See, e.g., LeadingAge's letter to Sec. Azar asking for a uniform reporting system. <file:///C:/Users/Marsha/Documents/CDC%20reporting%20letter%20final.pdf>

- **National testing strategy** to eliminate duplicative, contradictory policies; and public financing to ensure that private entities are adequately compensated for mandatory requirements.⁴
- **Public access to PPE**, to eliminate the “hunger games” scenario where providers are mandated to use PPE but PPE is in short supply globally, leaving providers to find PPE by themselves, hoping their standard supplier has access or they can find some other supplier who is reliable and honest. Public access would also reduce the problem of price gouging, where the cost of a disposable gown increases from 25 cents pre-pandemic to \$4.00 during the pandemic. It truly is the federal government’s responsibility to manage access to and distribution of rare but life-saving essential products.
- **Emergency preparedness infrastructure** must include aging services. Examples include retaining the strike teams that some states created earlier in the pandemic (and now funded through CMS); and effective use of the public health workforce to supplement workers who are in quarantine or sick leave. This is essential not only for nursing homes but all congregate and senior housing, including HUD housing where low-income seniors at highest risk live in the “community” but with little access to necessary services (e.g., wifi, access to testing and vaccines). Aging services providers must be at the table at all levels. This is the lesson we thought was learned from Katrina, but it is not clear we did.
- **Telehealth/technology/broadband** issues of fairness and access remain. We clearly need to improve broadband access in rural areas; provide access to reduced rates for rural home health providers as we do for nursing homes; reimburse telehealth capabilities in non-rural nursing homes and other care settings; and address access and availability in community settings, for example by allowing HUD housing providers to wire their apartment buildings for wifi for tenants.
- **Effective public/private partnerships.** The long-term care pharmacy partnership to deliver vaccines to almost every nursing home is a good example of the federal approach that has been sorely missing. While not perfect, with improvements it could be a model for addressing specific needs in future emergencies.

The second cause identified by Dr. Konetzka – large poorly funded nursing homes – embodies long-standing challenges to the way we deliver long-term services and supports. To address these issues, we must:

- **Focus on long-stay residents** – financed through Medicaid and to a much smaller extent, private pay – and rebuild our communities to address the social and health needs of these residents.
- **Rethink how nursing homes are conceived and structured**, moving to a smaller setting, with single rooms, again focusing on the needs of long-stay residents;
- **Address workforce issues**; the continual shortage of qualified staff at all levels and the serious underpayment especially at the direct care worker level must be addressed; LeadingAge’s

⁴ See, e.g., LeadingAge’s letter to Congressional leadership, <file:///C:/Users/Marsha/Downloads/Testing%20letter.pdf>

[Center for Workforce Solutions](#) and the [LeadingAge LTSS Center@UMass](#) are both dedicated to identifying solutions to these issues.

- **Address critical financing issues** associated with under-payment from Medicaid and the negative impact that underpayment has on quality and services. LeadingAge members regularly report that they must raise millions of dollars annually through charitable donations to provide high quality care because of underfunding from Medicaid.
- **Recognize that nursing homes are part of a continuum** of services primarily financed by public programs. We critically need a non-means tested public long-term care insurance program to ensure that all persons have an affordable means of paying for long-term care, are able to age or live with disability in the setting of their choice for as long as they can, with both quality of life and quality of care.

In addition, witnesses at this hearing and at other hearings before this committee and the Special Committee on Aging have raised concerns about how to ensure nursing homes provide high quality care, and how to respond to nursing homes that are poor performers.

Care for Seniors, the 8 point program LeadingAge and AHCA have put forward, addresses many of the concerns raised during this hearing, and identifies public and private financing mechanisms to implement these policies.⁵

1. To enhance quality of care:

- a. **Enhanced Infection Control:** we strongly agree that infection control is critical and have proposed updating the current guidelines to address some of the challenges around workforce and training to make it possible to employ infection control specialists in each nursing home.
- b. **RN 24/7:** many of our members already employ registered nurses on a round-the-clock basis. In many parts of the country, however, there is a shortage of qualified nursing staff, and Medicaid, the primary payer for long-stay nursing home residents, is not funded in a way that covers current costs, much less the addition of, in effect, 6 full time nurses just to have one nurse on staff all the time. We provide a number of recommendations on how to implement expanded staffing.
- c. **Maintaining a minimum 30-day supply of PPE,** to address current and future infectious diseases and other conditions that require extensive protective equipment. Again, this will require not just action by nursing homes but also a commitment from the public sector to ensure that adequate supplies are available continually.

2. Recruit and Retain a Long Term Care Workforce Strategy:

- a. For decades the nursing home field has been plagued by shortages in staff, whether because it is easier and more lucrative to work in settings like hospitals, as Ms. Ramos so

⁵ <https://leadingage.org/care-our-seniors-act>

accurately testified, or because there simply are not sufficient numbers of persons interested in this field. As mentioned above, LeadingAge’s Center for Workforce Solutions and LTSS Center have been working on attracting workers for many years, culminating in the ground-breaking work, ***Making Care Work Pay***, which addresses the economic benefits and necessity of providing a living wage, along with the challenges of implementing this policy.

- b. Care for Seniors recommends a multi-phase tiered approach to supply, attract and retain the long term care workforce, including leveraging federal, state, and academic entities to provide loan forgiveness for new graduates who work in long term care, tax credits for licensed long term care professionals, programs for affordable housing and childcare assistance, and increased subsidies to professionals’ schools whose graduates work in nursing homes for at least five years.

3. Improve Systems to be More Resident-Driven

- a. **Survey Improvements for Better Resident Care:** Over many years, numerous studies by private and public entities have documented failures in the survey system, from inconsistent results to failure to identify and fix significant deficiencies. This over 30-year old system needs to be revamped to reflect modern thinking on addressing medical errors (e.g., using the elements in the patient safety model) and the significant changes in nursing homes and the residents we serve since this system was inaugurated in 1987. LeadingAge strongly supports the study currently undertaken by the National Academies of Science, Engineering and Medicine (NASEM) reexamining the current way we identify, measure and enforce quality of care and quality of life in nursing homes.⁶ Additionally, Care for Seniors makes recommendations that support development of an effective oversight system and processes that support improved care and protect residents.
- b. **Chronic Poor Performing Nursing Facilities and Change of Ownership:** A corollary of the failure of the current survey and certification system is the continued and seemingly intractable problem of chronic poor performers. LeadingAge supports the Nursing Home Reform Modernization Act (S. 782) introduced by Senators Casey and Toomey as an excellent example of a creative way to address improving care by creating a separate program within CMS to provide mandatory counseling, education and assistance for poor performers. In Care for Our Seniors, we propose a detailed process for working with poor performers: (1) Identify chronic poor performing facilities; (2) Conduct an analysis to determine the reason for chronic poor performance; (3) Develop a turn-around plan; (4) Monitor progress; and (5) Determine if the plan of correction goals have been met or the need for plan revisions. Finally, we “bite the bullet” and state, “If milestones are not met within six to 24 months (median time of one year), a temporary manager, change in management/ownership or the closure of the facility may be required.”

⁶ <https://www.nationalacademies.org/our-work/the-quality-of-care-in-nursing-homes>

- c. **Customer Satisfaction:** As we note in this last recommendation, nursing homes are the only Medicare health care provider that does not include customer satisfaction in the data collected and reported by CMS. Hospitals, hospice, and home health collect customer satisfaction, which is part of their publicly reported data. We recommend adding a customer satisfaction measure to the 5-star rating system, to help consumers and family members monitor the quality of nursing homes.

Finally, we should use this crisis as an opportunity to think more broadly about how we want to age, what services we will need in the future, how we will want to live, and how we expect to finance the aging services ecosystem. While we understand the importance of addressing care in nursing homes during the pandemic, we would note that more older adults live in the broader community than in nursing homes. We have very little data on the impact of COVID on older adults who receive LTSS in the community.

We must, therefore, also address loss of community-based services. Closure of adult day programs, PACE, senior centers, loss of access to HCBS and home care workers all had a negative impact on seniors now and will in the future. LeadingAge members who provide home-based care, whether through Medicare, Medicaid or private pay, had trouble accessing PPE, testing, and vaccines, which would be essential to their being able to serve their clients. The adults we serve as well have had difficulty being prioritized for testing and access to vaccines, especially home-bound clients. In this respect, a more robust public health infrastructure, with community mobile clinics, is critical, as well as addressing the needs of individuals in HUD-supported housing.

In conclusion, we thank you for the opportunity to engage in this very critical endeavor, improving the care and services we provide to the most vulnerable and frail in our society. This pandemic has been devastating to the people we serve, our staff, and our leadership. We must learn the right lessons so that we are able to come out of this crisis stronger and able to provide older adults with true quality of life and services.