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McKnight's LONG-TERM CARE NEWS

Guidance Released on how to Resume Visits, Community Activities at Long-term Care Facilities

Written by: Danielle Brown

3/2/2021

The process toward fully opening long-term care facilities to visitors and resuming group activities should be done using a gradual, step-by-step approach in order to mitigate the risk of potential COVID outbreaks, according to a leading provider group.

Activities should first be conducted by wing or unit, and only under the guise of vaccinated workers, for example.

The recommendations were issued in guidance released on Monday by AMDA — The Society for Post-Acute and Long-Term Care Medicine on how providers should approach reopening their facilities as vaccine access becomes more widespread and cases begin to plummet. Last week, provider association LeadingAge called on federal agencies to reconsider its regulations on indoor visitation at nursing homes.

The organization explained that taking a measured approach early will give providers and staff a chance to continuously evaluate what works for residents in a safe manner.

"Vaccine delays, vaccine hesitancy, admission of new, unvaccinated residents, and ongoing community COVID-19 cases conspire to prolong the threat of COVID-19," said Christopher Laxton, AMDA executive director.

"Considering these challenges, facilities must take a thoughtful approach to reopening. In doing so, it should be possible to safely balance the risks of COVID-19 with the negative impact of restrictions in activities and visitation," he added.

They recommend beginning group activities among residents within a single unit or wing at a time, with staff who have been vaccinated, as opposed to resuming normal communal functions all at once for the entire building.

Resumptions to group dining and other activities also should include continuously reminding residents about mask wearing, social distancing and hand hygiene. The same should also go for any potential visitors.

The organization added that the process should closely evaluate the impact the changes have on workflow as part of their quality assurance and performance improvement program.

“This involves monitoring for new cases of COVID-19 infection in the building and continuous quality improvement around the new processes. Any new COVID-19 infection among staff or residents represents an outbreak and should trigger a return to previous restrictions, in conjunction with guidance from Centers for Medicare and Medicaid Services (CMS) and most states,” the recommendations noted.

The guidance also calls for providers to:

- Encourage all staff, residents and visitors to be vaccinated against COVID-19 and seasonal influenza,
- Have staff schedule and supervise all visits with residents,
- Continue to screen all visitors for COVID-19 each day they come to the facility,
- Require all visitors wear a medical-grade mask issued by the facility at all times, and
- Ensure their developed policies and procedures are in accordance with CMS, the Centers for Disease Control and Prevention, local and state requirements.

McKnight’s LONG-TERM CARE NEWS

COVID Death Rates are Way Down. Now Comes the Hard Part

Written by: James M. Berklan

2/26/2021

If you have ever been a parent of a young child, you undoubtedly have endured the mile-long question.

“Dad, can I stay up a little longer — pleasepleasepleasepleasepleeeeeease?”

“Mom, can I go to Tommy’s? CanI?CanI?CanI?CanI?CanI?HisparentssaiditwouldbeOK!CanI?”

Whether or not you’ve been a parent, if you run a nursing home, you’re liable to be experiencing a version of it soon. If you haven’t already.

The incredible drop in nursing home COVID-19 infections and deaths recently is jacking up expectations like a mouthful of Starburst candy in a child just before bedtime.

Residents are getting vaccinated in large percentages and an increasing number of their family members are too. After a year of good behavior, it’s only natural that they will start hitting you with questions about when normal visits can resume.

Answering those pleas is going to be tricky. A big issue is whether vaccinated individuals can still be virus carriers.

Most scientists believe they can. But like so much with this novel (i.e. “new”) coronavirus, more study is warranted.

Regardless, intent family members may counter: What if resident and loved ones are both vaccinated against 95% of the potentially harsh symptoms? At what price should resident isolation continue?

How much risk providers and their charges are willing to assume is liable to take center stage. Just not very soon. Public policy makers do not appear inclined to nudge open any door yet to potential outbreaks.

In many places, just a single case involving a staff member, resident or other visitor, would send an entire facility back into weeks of lockdown.

Nonetheless, groups such as LeadingAge and AARP have already asked publicly for updated visitation guidance. Expect the American Health Care Association and others to join in.

The key is going to be getting amendments to certain governors’ executive orders that demand vast retrenchment if even a single case appears on campus.

All residents and workers shouldn’t have to pay the price for one positive case that might pop up. That’s especially true if the facility has already completed its three vaccination clinics, and new residents and workers are immediately offered inoculation. It’s a lot more complex, however, than the vaccinated simply saying, “I got mine.” You can be sure regulatory discussions will be thick with liability and care implications.

While policy makers from the Centers for Disease Control and Prevention and the Centers for Medicare & Medicaid Services on down sort out the next steps, there are some things providers should be doing in anticipation of reopening.

Start preparations for Phase 2 of the vaccination program. So urged Marquis Companies and Consonus Healthcare President and CEO Phil Fogg Jr., the featured speaker at a popular *McKnight’s* webinar Thursday. (It can still be viewed in archive — just head to the registration page.)

Make sure your local pharmacy partner is properly applying for state and federal approvals. Develop your workflow capabilities now. The county might tell you one thing about visitations, but the state and feds might not agree, so you need to be ready to pounce on opportunity when unified progress occurs.

Plot your future screening processes. How will rapid testing be a part of the strategy? Will you offer vaccinations to a broadening net of family members to help the overall cause? When? How?

Because you will continually be welcoming new workers and residents, these are not once-and-done considerations.

At some point, you need to consider what level of risk you will settle on, Fogg emphasized. After all, when restrictions are eased — and make no mistake, they will be eventually — you might be willing to shoulder greater uncertainty if it means reuniting residents with their families quicker.

You also could be more willing if it means finally giving families and residents answers to pained questions that have been forming all these many long months.

McKnight's LONG-TERM CARE NEWS

When Access isn't Enough: Promoting COVID-19 Vaccine Acceptance Among Minority, Frontline Nursing Home Workers

Written by: Richard Feifer, M.D., MPH & LaShuan Bethea, J.D., BSN

2/26/2021

Nursing home staff are working tirelessly to protect our most vulnerable population against COVID-19, but many remain wary about getting vaccinated. The issue is particularly acute among minority groups, consistent with data and polls among the general population.

Herd immunity depends on reaching high vaccination rates across the nation, so vaccine hesitancy is of growing concern. One thing is clear from our experience: Effective communication and peer encouragement are the keys to boosting vaccination rates.

Recent data on COVID-19 vaccinations by race/ethnicity released by the Kaiser Family Foundation suggests vaccine access is creating racial disparities in COVID-19 vaccinations. Yet, in nursing homes, where access is 100% guaranteed, the bigger hurdle is actually vaccine acceptance, particularly among people of color and frontline staff.

As of Feb. 16, data collected across Genesis' nearly 300 nursing homes show that overall, more than 63% of its nursing home staff have been vaccinated – well above the 37.5% national average for the first month of vaccinations, as recently announced by the Centers for Disease Control and Prevention. However, our Black and Hispanic staff have been 35% less likely to accept vaccination than White staff.

By contrast, approximately 85% of skilled nursing residents in our centers have been vaccinated, with similar patterns of lower acceptance rates among people of color.

According to the KFF report, 37% of Hispanics and 43% of Blacks plan to wait and see how the vaccination affects their peers before making the decision to take it themselves.

Many cultural, societal and historical reasons drive vaccine hesitancy among minority groups, including:

The historical medical mistreatment of minority groups, including Blacks, Hispanics and Native Americans in the U.S. We saw this first-hand during the 30-year Tuskegee experiment where Black men with syphilis were denied treatments so researchers could study the effects of the disease.

Infringements on minority women's reproductive rights, including sterilization programs without consent, particularly among Hispanics and Native Americans.

Chronically underfunded federal health programming for Native Americans and Alaska Natives leading to government distrust and inadequate access to medical care.

Compounding this is a common lack of understanding of how the COVID-19 vaccines work and an absence of studies on long-term side effects, paving the way for mass misinformation and fear.

As healthcare professionals, we understand the skepticism surrounding COVID-19 vaccination. But as a nation, we can – and we must – overcome this by listening to the concerns of those who are hesitant and taking steps to minimize their distrust.

If we do not, more people will contract the virus, and the nation will see more suffering and death. In nursing homes, it's particularly important that frontline workers get vaccinated to protect both themselves and nursing home residents.

To get there, we must focus on reaching every community in a focused and empathetic way. As American Medical Association Chief Health Equity Officer Aletha Maybank, M.D., has said, messaging needs to be deliberate to surmount mistrust because of "well-documented harms both in stories that have been passed down across generations and in the present lived experience."

Last September, Genesis started educating patients, residents, staff and families about the importance of being vaccinated, months before the first vaccines were approved or available.

As trends demonstrated vaccine hesitancy among Black, Hispanic and Native Americans, we met with our Diversity, Equity and Inclusion Committee to better understand the nuances of vaccine hesitancy and educate committee members about the vaccine. We created opportunities to hear and answer every point of hesitancy or concern with a combination of compassion and factual information. Members of the committee also participated in "Ask The Doc" sessions to encourage open discussion of culturally sensitive questions with frontline staff.

Another impactful method for people in doubt involves testimonials from trusted co-workers and community leaders. We used social media to highlight vaccine experiences and the journey to acceptance of Black, Hispanic and other minorities.

The Belvedere Center, located in Chester, PA, hosted Chester Mayor Thaddeus Kirkland and Darrell Jones, president of the Chester NAACP, who were vaccinated onsite at the center's first vaccine clinic. Both spoke to employees about the importance of vaccine acceptance. Initially, 52% of staff received dose one of the vaccine, but acceptance jumped to 69% by clinic 2 among this predominantly Black workforce.

A personal, encouraging word-of-mouth moment from a trusted voice can help overcome vaccine hesitancy. Plainly stated, we urgently need to spread the word about the importance of vaccination to save lives. We believe this can be accomplished by partnering with leaders within minority communities to help build trust and share truthful information about the vaccine in a way that is patient and empathetic to people's concerns and experiences.

Skilled Nursing News

Sloan: Better Wages a Critical Component of Any Fix for Nursing Homes after COVID-19

Written by: Maggie Flynn

3/1/2021

The day-to-day operations of running a skilled nursing facility, were upended by the COVID-19 pandemic — along with the core business model of post-acute and long-term care in America.

For many operators, the pandemic has exposed the flaws and systemic challenges of the space, both on the regulatory and operating sides. And as cases continue to decline in long-term care facilities amid vaccination efforts, more and more effort is going to go into addressing those challenges — if there is the will and effort to do so.

Many different solutions have been proposed, and there is no one quick fix for the many problems baked into the long-term care infrastructure in the U.S. The regulatory, clinical, and financial modes of operation for nursing homes will all need to undergo some level of change to fully respond to the lessons of COVID-19.

For Katie Smith Sloan — the president and CEO of LeadingAge, the trade association representing nonprofit senior living and care providers — all of those components need attention.

A commentary piece in Skilled Nursing News, published on January 11, called on providers to have a plan to improve as they lobby for more government aid, and Sloan reached out to SNN to respond. Her vision for the future calls for reform on many fronts, including the reimbursement paid to SNFs — with the goal of bolstering the wages paid to frontline caregivers.

This conversation was recorded on February 18, and has been condensed and edited for clarity.

Let's just start with the commentary itself — what is LeadingAge's reaction to the call for operators to set up their own plans to improve?

We agree with your underlying premise that we must all learn from COVID, and that changes are needed — both at the SNF level, the provider level, but also with the government, both federal and state. Once COVID is behind us, whenever that will be, we can't simply revert back to old ways of doing business.

So LeadingAge is very much committed to a forward-looking agenda to take action that addresses some of the systemic problems and builds solutions to fix them. I think a lot of the underlying issues here come back to the fact that we as a country have really undervalued and underinvested in older adults, and their care providers, for decades. The needs and lives of older Americans are often ignored, and I think what's happened in fighting the pandemic — providers have been left to battle largely on their own.

That's certainly a frustration looking back, but we can't dwell on that. Really, what we're looking to is a future in which nursing homes, regardless of who they serve, are driven by person-centered care, by excellence in quality, by qualified staff and a physical setting that reinforces both the dignity as well as the wellbeing of the residents that are being served.

I would say this is not our responsibility alone. I think this is a shared commitment between providers and consumers and government leaders and communities themselves to really commit to reimagining, rethinking nursing homes through a 21st-century frame. From my perspective, what that means is we have to think about: Who do they serve? How do they serve them? How are they paid? How are they regulated? How are they staffed?

It's not just a Band-Aid. It's not just a quick fix, but to me it's much more of a fundamental rethink. Once we have that new frame for nursing homes, then we absolutely need the resources to support and sustain that transformation, whatever it ends up looking like, and not treat nursing homes as the stepchild in our health care system. Because they in fact do play a unique and essential role that must be recognized and supported; that has really come to light in COVID, the unique role of nursing homes and the lack of support.

The other thing I would say is in your commentary, you talk a lot about workforce and frontline workers, and we

agree completely. Frontline workers are the heart of nursing homes, and we agree that they need more support. We released a report in September [2020] called "Making Care Work Pay," and we worked with a labor economist to look at: What would it take and what would be the impact of paying our direct care workforces a living wage?

Rather than look at it from a moral point of view or an ethical point of view, we really said: Let's just take an economic look at this. And what we learned through that report is that it basically pays for itself over time, that the benefits in terms of turnover or lack thereof, in terms of productivity, in terms of getting direct care workers off of public benefits because they're being paid more and they don't need public benefits. The economic contributions to the broader community pays for itself over time.

So we agree that we need to be looking at livable wages. But we also need to take a broader look at this, and focus on professionalizing the direct care workforce, and clearly wages are a piece of that. But how do we train them? What kind of career path are we providing for our direct care workforce? What kind of workplace cultures are we creating that really foster career growth? We're looking at this in a much more holistic way than just wages by itself, but wages are certainly an important piece of this.

So where we are now is putting together a broad coalition — we're not the only ones looking at this issue — and then figuring out what our path forward is, what's the action plan that supports it. Obviously it's going to involve investment at the outset, both by providers themselves in terms of the workplace cultures, but also by governments in terms of being able to pay workers more.

That's a big part of our agenda going forward. You can't have people who we call essential during a pandemic and not treat them as essential in all aspects of that work.

One of the questions I wanted to ask was about the priorities LeadingAge would focus on for improvement — specifically areas that could be worked on now — and it sounds like wages and workforce would be among those. Are there others, and if so, why are they top priority?

We're following the work of the National Academy of Medicine really closely. I'm sure you're familiar with the study that they're doing; here we are 34 years into the same regulatory framework we've had for nursing homes with no major shifts in how we regulate nursing homes. So the National Academy of Medicine is taking a look at: What does the nursing home of today look like?

I would argue that the people who live in nursing homes, the people who work in nursing homes — that our care practices have changed a lot. Our understanding of how to, for example, support people with dementia has changed, our understanding of physical environments. There's so much that we've learned and changed over the last 34 years, and we're sort of saddled with a regulatory frame that has not kept up with it. What the National Academy of Medicine is doing is taking a look at what needs to change in order to be contemporary with best practices, but also really set us up for the future, with a laser-focus on quality.

We're eager for that, and our hope is that we can be patient enough to see what the results of a study like this are, before we jump into throwing lots of new regulations at nursing homes. It's an independent body with thoughtful folks that are taking a dispassionate look at nursing homes. Providers are not part of that discussion by design. It's something that first of all is long overdue, but second of all, we're eager to see what they come up with.

In the very short term, we have to address issues around just survivability of the older adults; nursing homes themselves; continued vaccination; regular and rapid testing and the funds to cover that; access to affordable, abundant PPE [personal protective equipment]. And then it comes back to staffing at the end of the day, right? Making sure that we have enough staff to provide the kind of quality care that homes need.

It's rough out there right now. I talked to a member not long ago who had 73 openings for CNAs [certified nursing assistants] and no applications. I talked to another member who said that the cost of a nurse through a staffing agency has gone from somewhere in the $20s to somewhere in the $90s per hour.

I talked to another member who said that her organization will spend $1 million this year on testing, because the supplies that they get through their state are not sufficient — so they have to go out and supplement in the marketplace in order to keep up with regular testing of staff, testing of visitors. Their state allows for compassionate care visitors who can visit twice a week for an hour, but every time they walk in the building, they have to be tested. Those are expenses that are just unsustainable over the long run.

And they're essential expenses; they're not "nice to do," they're "need to do." That becomes our advocacy agenda, which we're aggressively pursuing right now with the Congress.

Then, obviously, states have had a huge role to play in COVID, and they need to continue to prioritize older adults for vaccines. We have members who are nursing homes, but we also have members who do a lot of community services and for the most part, they have not formally been included in vaccine prioritization. Those who live at home but go to an adult day program during the day, or those who live in affordable housing, those individuals who were receiving home health services, for example — there are a lot of other needs out there.

The partnership program [for vaccination] was a huge benefit to nursing homes and assisted living, but it's not the end of the game.

What are some specific initiatives or pieces of legislation that you would like to focus on with the new administration?

Certainly the stimulus bill that's going through Congress now is something that's very important to us, because it includes funds for testing and PPE and continued support for vaccine distribution. That's essential.

The other big issue for nursing homes is Medicaid funding, and will there be any kind of adjustment to the FMAP [Federal Medical Assistance Percentage] going forward? Obviously that's a big issue at the state levels as well. I think a lot of the activity at least around Medicaid will be at the state level, and how stretched dollars are going to be distributed, and whether or not bumps for — I'll just call it generically hazard pay — will continue, and how long. Every little bit helps providers right now, and ultimately it's really not about the bottom line as it is about being able to continue to provide high-quality care to residents and to continue to support their staff.

I'm not sure what the current numbers are in terms of occupancy, but I think it's in the 80% range, so providers are operating with less revenue as a result. That obviously puts a big strain, because your expenses don't necessarily go down commensurate to lower occupancy.

We will have a new head of CMS [Centers for Medicare & Medicaid Services], and so getting to know her and her vision for aging services and nursing homes in particular, and where she's going to place her emphasis, is something we're all paying close attention to.

With the need for a new frame for nursing homes that you mentioned at the start, can you ballpark how many of LeadingAge's members are focused on providing skilled nursing or nursing home care?

We have about 2,000 members who provide nursing home care, and that would include both stand-alones and nursing homes that are part of continuing care retirement communities (CCRCs). We have nursing homes connected to hospital systems, so a lot of variations on that, but in terms of the overall structure of the organization, there are about 2,000 that provide nursing home care.

The reason I'm curious about that is that over the past couple years of covering skilled nursing, I've been told that it's not an easy landscape for non-profits, with many exiting the standalone skilled nursing space. In Philadelphia last year, for instance, a non-profit SNF had to sell to a for-profit company. The nursing home landscape doesn't appear very hospitable to the non-profit operating model at least as I see it — does that seem accurate to you, and what would make it easier for non-profits to work in this space and provide this kind of care?

I think it's a tough operating landscaping, period, but particularly for an organization that is not providing any other services than nursing home care, it's really hard. Rather than close their doors, many of our non-profit members will engage in additional services, so maybe they'll add an adult day program or add hospice services or start a hospice agency, so they can continue to maintain their core mission of providing nursing home services — but provide services to additional individuals to shore up the whole organization.

We're seeing a fair amount of that. The fundamental problem that nursing homes face in terms of their ability to stay afloat is the Medicaid rate. A home that has a large number of Medicaid beds — in so many states, the Medicaid rate is just woefully inadequate to covering the cost of care. I'm not telling you anything you don't know, but in the meantime, their costs keep rising. The costs of staff — we've talked about paying livable wages, but even the cost of equipment — everybody's costs are going up, and yet they're being paid at the same rate.

So what do you do to cover those losses? You fundraise, which non-profits can do; there's only so much out there to fundraise, and that means they're spending a fair amount of time fundraising. Or they provide some additional kinds of services that may generate some revenue that will support it. But they're not willing to cut on quality, and if they can't provide quality care with the revenue that they have, they're going to either look at a different business model, or closing their doors, or selling.

I've talked with members who, for example, can't hire enough staff to be able to even staff a whole wing of their nursing home. So they have to close that wing because they don't have the staff to provide adequate support. It's a challenging environment. I admire our nursing home members who are really toughing it out and figuring out how to make it work, but there's a very distinct reason why they're expanding their missions to provide services to older adults in other ways as well.

Is that something that would be part of what you'd want to see more of going forward, the expansion of different parts of the continuum? Or is there something else you'd like to see be done to make the operating landscape easier for everyone, but for non-profits in particular?

I would step back from the question and say that I think our overall vision is an integrated, connected system of services and supports for older people so that we don't operate in silos. As you know, aging is not a linear process. People have different needs at different times for different amounts of time. They also have different preferences and desires about services and supports, they have different family circumstances.

What LeadingAge believes is that ultimately what we need is a much more integrated system, which means that back to your question, a nursing home that begins to provide additional services begins to create that easier transition between services and supports, but also much greater opportunity for integration. I think that's the direction we need to go, just overall as a society, in how we care for and how we create an infrastructure to support older adults.

When it comes to the non-profits exiting the skilled nursing space, I've seen reports that cite the good work non-profits do compared to for-profit facilities, pointing to the outcomes on COVID-19 in particular. But what I see less of is the fact that so many non-profits are leaving the space and can't make it work.

Exactly. I think that's absolutely true. I also think there's another factor, which maybe is less about the closure part, but non-profits don't have as ready access to capital. So if there's an opportunity to acquire another nursing home, it's usually more difficult for a non-profit to actually expand through acquisition than it is for a for-profit. It's just a function of how the capital markets work and how non-profit governance works, and it's kind of a fact of life.

But it means that if there are opportunities to expand through acquisition or merger, those are just harder for non-profits to orchestrate.

Is there anything else that you wanted to address or talk about, or respond to from the January 11 commentary?

I think the rethink, and where we need to go from here, is not just a nursing home issue. I think it's an overall societal issue. There are multiple stakeholders involved, and we feel like they all need to be at the table, and we need to have that open and honest conversation about where we go from here. We look forward to setting that table, being at the table, because these conversations and this rethink is, to me, essential. And it's urgent.