



Coronavirus Commission for Safety and Quality in Nursing Homes

Commission Final Report September 2020

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Executive Summary

The global outbreak of the Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) constitutes a public health emergency unlike any in living memory. The transmission characteristics of COVID-19—the disease the virus causes in the human body—result in brisk community spread. Moreover, the recovery trajectory for those who survive the initial acute attack of the virus remains to be seen. The scientific community’s understanding of the virus and development of effective treatments for COVID-19 is nascent.

Nursing homes have emerged as prime hotspots for COVID-19 outbreaks. In the United States, nursing-home residents and staff represent only 8% of COVID-19 cases, yet bear 41% of COVID-19 deaths based on data reported August 13.¹ Beyond experiencing the ravages of the disease itself, residents have been traumatized by the impact of nursing homes restricting visitors and curtailing group activities in an effort to mitigate spread of this virus. The resulting physical and mental harm—and increased vulnerabilities—to residents is common knowledge and troubling. Furthermore, the pandemic’s spread in these institutions has exposed and exacerbated long-standing, underlying challenges in this care setting. For example, dynamics of the U.S. federal system—where public health, emergency management, health services, and long-term care authorities function at federal, state, and local levels—have resulted in a patchwork approach to infection prevention and control that many believe has contributed to our nation’s inability to contain the spread of the virus.

Purpose of the Commission and This Report

The Centers for Medicare & Medicaid Services (CMS) tasked MITRE, the operator of the CMS Alliance to Modernize Healthcare (Health FFRDC), with an urgent assignment: Convene a commission of experts to address safety and quality in nursing homes in relation to the public health emergency. The main purpose of the independent Coronavirus Commission for Safety and Quality in Nursing Homes (Commission) was to solicit lessons learned from the early days of the pandemic and recommendations for future actions to improve infection prevention and control measures, safety procedures, and the quality of life of residents within nursing homes. CMS outlined four objectives for the Commission.

1. Identify best practices² for facilities to enable rapid and effective identification and mitigation of Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) transmission (and other infectious diseases) in nursing homes.
2. Recommend best practices as exemplars of rigorous infection control practices and facility resiliency that can serve as a framework for enhanced oversight and quality monitoring activities.
3. Identify best practices for improved care delivery and responsiveness to the needs of all nursing home residents in preparation for, during, and following an emergency.
4. Leverage new data sources to improve upon existing infection control policies, and enable coordinated actions across federal surveyors and contractors (as well as state and local entities) to mitigate the effects of SARS-CoV-2 and future emergencies.

Likewise, CMS asked for the Commission to focus its recommendations on actions within CMS’s authority and that could be undertaken immediately or within the six months following this report’s delivery. This final report, prepared by MITRE, documents the Commission’s output.

Organization, Perspectives, and Process

The 25 Commission members hailed from around the country with diverse expertise and viewpoints ranging from nursing home resident, consumer advocates, and nursing home owners and administrators to infectious disease experts, academicians, state authorities, and others. The Commission convened nine times between June 23 and August 19. The Commission used the four objectives provided by CMS and its collective knowledge of the nursing home system, to frame its discussions. Analysis of public input solicited via the Commission’s website and discussion of relevant CMS and other federal actions to date also informed the Commission’s work. Figure 1 illustrates the Commission process and outputs.

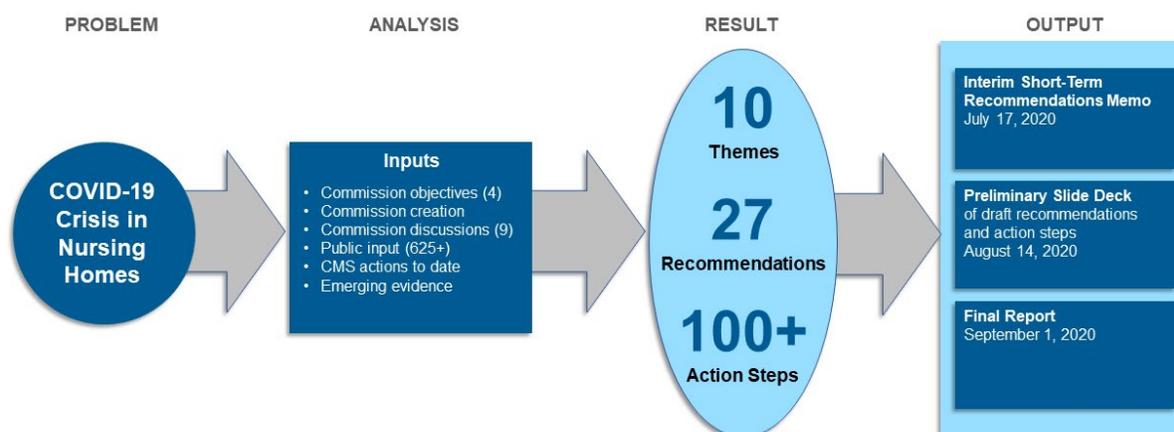


Figure 1. Commission Process and Outputs

The Commission emerged from its convenings with 27 recommendations and accompanying action steps organized into 10 themes. These themes intersect with the Commission’s four objectives, and reflect responses to:

- Ongoing supply and affordability dilemmas related to testing, screening, and personal protective equipment (PPE)
- Tension between rigorous infection control measures and quality of life issues that exist in cohorting and visitation policies
- A call for transparent and accessible communications with residents, their representatives and loved ones, and the public
- Urgent need to train, support, protect, and respect direct-care providers

- Outdated infrastructure of many nursing-home facilities
- Opportunities to create and organize guidance to owners and administrators that is more actionable and to obtain data from nursing homes that is more meaningful for action and research
- Insufficient funding for quality nursing home operations, workforce performance, and resident safety.

Each of the 27 Principal Recommendations are deliberately paired with specific action steps. The intent is that CMS would implement each principal recommendation in conjunction with its associated action steps to understand and realize the Commission’s vision.

A Call to Further Action

To reduce suffering and to save the lives of residents and staff, CMS can implement or initiate the Commission’s actionable recommendations in relatively short order. In some cases, CMS will need to assume a greater leadership role working with its federal partners and state, local, tribal and territorial (SLTT) authorities to determine which entity has authority to accomplish the Commission’s recommendations and action steps. Even so, with the nation’s attention on COVID-19 in nursing homes and the devastating consequences of leaving long-standing systemic issues unaddressed, the Commission urges CMS, as the lead federal agency with nursing home quality and safety oversight, to lead, to advocate, and to ensure accountability for nursing homes and their residents and staff in the national pandemic response. The time has come for a turning point in nursing home care. The Commission envisions a person-centered, resilient system of care that is better for the next generation—one that more deeply values and respects older adults and people with disabilities as vital to the fabric of American society. Figure 2 presents this framework.

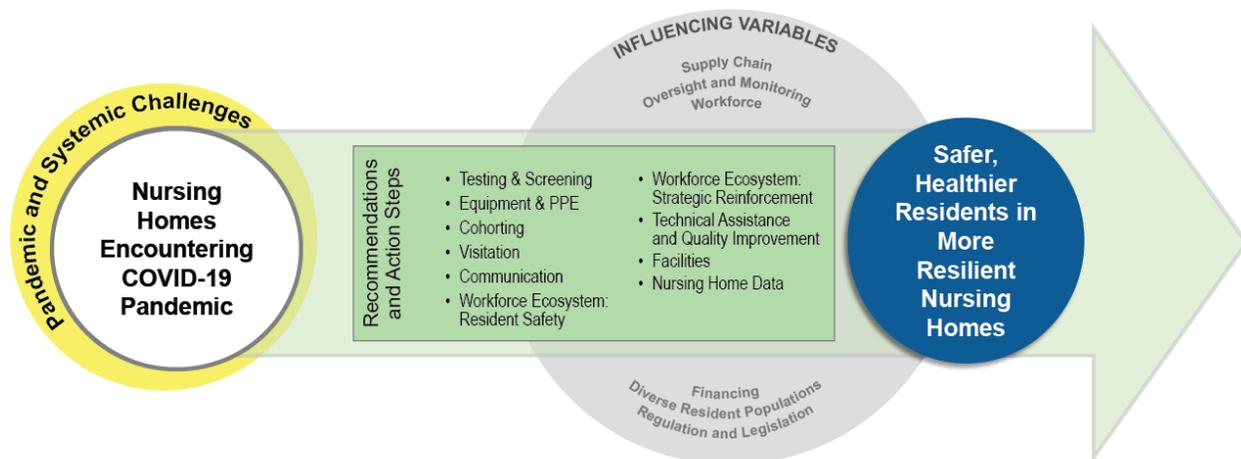


Figure 2. Commission Recommendation Framework

The Commission is confident CMS has the tools and can leverage its influence to make this vision a reality in partnership with government, academia, the private sector, nursing home owners, administrators, staff, residents, families, essential care partners, legal surrogates, and advocates.

Principal Recommendations

Please navigate to each theme’s analysis (using the provided links) for an overview of relevant findings and evidence, the specific action steps to implement each recommendation, and information about the Commission’s endorsement.

#	Theme	Recommendation
1A	Testing and Screening	<p>Immediately develop and execute a national strategy, coordinating with federal partners and SLTT authorities, for testing and delivering rapid turnaround of results (i.e., results in less than 24 hours) in nursing homes, in combination with CDC-recommended screening protocols. Allow nursing home owners and administrators to tailor the strategy based on community prevalence and resource availability in partnership with federal and SLTT authorities.</p> <p>[See associated action steps for this recommendation]</p>
2A	Equipment and PPE	<p>Assume responsibility for a collaborative process with federal and SLTT partners to ensure nursing home owners and administrators can procure and sustain a three-month supply of high-quality supplies of PPE. This process must provide accountability and oversight.</p> <p>[See associated action steps for this recommendation]</p>
2B	Equipment and PPE	<p>Provide specific guidance on the use, decontamination, and reuse of PPE, working with federal partners, including CDC, FDA, and OSHA.</p> <p>[See associated action steps for this recommendation]</p>
2C	Equipment and PPE	<p>As needed, collaborate with other federal and state agencies to provide guidance on training to all clinical and nonclinical facility staff on proper use of PPE and equipment, according to available manufacturer specifications. (See also recommendation on Infection Preventionist under Workforce Ecosystem.)</p> <p>[See associated action steps for this recommendation]</p>
3A	Cohorting	<p>Update cohorting guidance to balance resident and staff psychological safety and well-being with infection prevention and control.</p> <p>[See associated action steps for this recommendation]</p>
3B	Cohorting	<p>Update cohorting guidance and reimbursement policy to address differences in nursing home resources (e.g., facility, infrastructure, staff).</p> <p>[See associated action steps for this recommendation]</p>

#	Theme	Recommendation
4A	Visitation	Emphasize that visitation is a vital resident right. Update and release consolidated, evidence-based guidance on safely increasing controlled, in-person visitation prior to federal Phase 3 reopening. [See associated action steps for this recommendation]
4B	Visitation	Update and release consolidated, evidence-based guidance on effectively planning for and implementing virtual visitation tools and techniques. [See associated action steps for this recommendation]
4C	Visitation	Provide resources to help nursing home staff assess and improve the mental health and psychosocial well-being of residents during and after the pandemic. [See associated action steps for this recommendation]
4D	Visitation	Assess, streamline, and increase the accessibility of COVID-19-related directives, guidance, and resources on visitation into a single source. [See associated action steps for this recommendation]
5A	Communication	Increase specificity and expand breadth of guidance on communications between nursing home staff, residents, and families. [See associated action steps for this recommendation]
6A	Workforce Ecosystem: Stopgaps for Resident Safety	Mobilize resources to support a fatigued nursing home workforce and assess minimum care standards. [See associated action steps for this recommendation]
6B	Workforce Ecosystem: Stopgaps for Resident Safety	Provide equity-oriented guidance that allows nursing home workforce members to safely continue to work in multiple nursing homes while adhering to infection prevention and control practices. [See associated action steps for this recommendation]
6C	Workforce Ecosystem: Stopgaps for Resident Safety	Support 24/7 RN staffing resources at nursing homes in the event of a positive SARS-CoV-2 test within that facility. [See associated action steps for this recommendation]

#	Theme	Recommendation
6D	Workforce Ecosystem: Stopgaps for Resident Safety	Identify and immediately leverage certified infection preventionists to support nursing homes' infection prevention needs. [See associated action steps for this recommendation]
6E	Workforce Ecosystem: Stopgaps for Resident Safety	Require nursing homes to employ infection preventionist(s) with educator capabilities. [See associated action steps for this recommendation]
7A	Workforce System: Strategic Reinforcement	Catalyze interest in the CNA profession through diverse recruitment vehicles; issue guidance for on-the-job CNA training, testing, and certification; and create a national CNA registry. [See associated action steps for this recommendation]
7B	Workforce System: Strategic Reinforcement	Professionalize infection prevention positions in nursing homes by updating regulations at 42 CFR § 483.80 so more fully qualified infection preventionists are available to serve in nursing homes. [See associated action steps for this recommendation]
7C	Workforce System: Strategic Reinforcement	Catalyze the overhaul of the workforce ecosystem in partnership with federal, SLTT, other public, private, and academic partners. [See associated action steps for this recommendation]
7D	Workforce System: Strategic Reinforcement	Convene a Long-Term Care Workforce Commission to assess, advise on, and provide independent oversight for modernization of workforce ecosystem. ³ [See associated action steps for this recommendation]
8A	Technical Assistance and Quality Improvement	Identify and work to achieve funding mechanisms for—or reprioritize activities of—technical assistance providers and other contractors to increase the availability of collaborative, on-site, data-driven, and outcomes-oriented support prior to, during, and after a public health emergency. [See associated action steps for this recommendation]
9A	Facilities	Identify and share with nursing homes short-term facility design enhancements to address immediate pandemic-related risks that can be implemented at minimal cost. [See associated action steps for this recommendation]

#	Theme	Recommendation
9B	Facilities	<p>Establish a collaborative national forum to identify and share best practices and recommendations; facilitate real-time learning on how to best use existing physical spaces. (Please refer to action steps following 9C.)</p> <p>[See associated action steps for this recommendation]</p>
9C	Facilities	<p>Collaboratively establish long-term priorities and seek appropriate funding streams for nursing homes to redesign and/or strengthen facilities against infectious diseases.</p> <p>[See associated action steps for this recommendation]</p>
10A	Nursing Home Data	<p>Standardize COVID-19 data elements, improve data collection, and identify supportive actions that CMS and federal partners will take in response to key COVID-19 indicators based on nursing home-reported data.</p> <p>[See associated action steps for this recommendation]</p>
10B	Nursing Home Data	<p>Create an easy-to-use, intuitive, and interactive technical infrastructure for nursing homes that streamlines the process of data reporting and consolidates dissemination of essential policy guidance, information about updated regulations, and other communications.</p> <p>[See associated action steps for this recommendation]</p>
10C	Nursing Home Data	<p>Enhance HIT interoperability to facilitate better communication, improve quality measurement standards, and coordinate integration of nursing home data with data from other health organizations.</p> <p>[See associated action steps for this recommendation]</p>

¹ Conten, M., et. al. (2020, August 13). *More Than 40% of U.S. Coronavirus Deaths Are Linked to Nursing Homes*. The New York Times. <https://nyti.ms/31mkr1B>.

² Given the novel nature of the virus and rapidly evolving state of understanding of the virus, the Commission was in the realm of “emerging evidence” and “emerging practices” with respect to some areas discussed.

³ MITRE-developed, derived from Commission discussion and/or public input.

1 Introduction

As the novel coronavirus 2019 (COVID-19) pandemic swept the globe in 2020, the Centers for Medicare & Medicaid Services (CMS) tasked MITRE, the operator of the CMS Alliance to Modernize Healthcare (Health FFRDC), with an urgent assignment: Convene an independent commission of experts to address safety and quality in nursing homes in relation to the public health emergency.^{4, 5} The main purpose of the independent Coronavirus Commission for Safety and Quality in Nursing Homes (Commission) was to solicit lessons learned from the early days of the pandemic and recommendations for future actions to improve infection prevention and control measures, safety procedures, and the quality of life of residents within nursing homes.⁶ CMS outlined four objectives for the Commission:

1. Identify best practices⁷ for facilities to enable rapid and effective identification and mitigation of Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) transmission (and other infectious diseases) in nursing homes.
2. Recommend best practices as exemplars of rigorous infection control practices and facility resiliency that can serve as a framework for enhanced oversight and quality monitoring activities.
3. Identify best practices for improved care delivery and responsiveness to the needs of all nursing home residents in preparation for, during, and following an emergency.
4. Leverage new data sources to improve upon existing infection control policies, and enable coordinated actions across federal surveyors and contractors (as well as state and local entities) to mitigate the effects of SARS-CoV-2 and future emergencies.

Commission Membership. On May 14, MITRE announced an open call for Commission nominations. MITRE selected 25 Commission members from a pool of more than 800 nominations and through a rigorous selection process. (The selection process is summarized in [Appendix B](#) in this report.) The Commission members hailed from around the country with diverse expertise and viewpoints ranging from nursing home resident, consumer advocates, and nursing home owners and administrators to infectious disease experts, academicians, state authorities, and others. CMS provided technical input to MITRE during the selection process. Commission membership was announced by MITRE and CMS on June 19.⁸ Timely convening was critical to enable CMS to leverage insights from the Commission as quickly as possible for the benefit of nursing home residents and staff.

Commission Convenings. The Commission met almost weekly between June 23 and August 7; they discussed the CMS objectives, the long-standing problems faced by nursing homes that were exacerbated by the pandemic, and recommendations to the agency and its federal partners to support residents and families as well as owners and administrators as they continue combating the pandemic on behalf of their residents and workforce. At CMS's request, the Commission sought to focus its recommendations on actions within CMS's authority and that could be undertaken in the short term, defined for this purpose as immediately or within the six months following this report's delivery (i.e., between September 1, 2020, and March 1, 2021). The Commission discussed immediate system stabilization actions for improving infection

control, safety, and quality of life, as well as system-recovery pursuits leading to sustainable improvement over time.

CMS Role. CMS leaders and staff joined the Commission’s meetings as guest speakers and invited guests during full-group discussions. CMS provided technical input to this report as further described in this section.

MITRE and Health FFRDC Roles. MITRE and two of its Health FFRDC Alliance partners, Atlas Research and Ripple Effect, filled several roles supporting the Commission.

- Dr. Jay Schnitzer, MITRE’s chief medical officer, served as the Commission’s moderator; Ms. Meg Kabat, Atlas senior director, served as the facilitator. All three organizations provided planning, research, and technical support.
- MITRE maintained communications with Commission members and the public through the Commission website and email account.
- On behalf of the Commission, MITRE sought public input to align with the four Commission objectives, and to allow the public to formally note their support of nursing home residents and staff.⁹ Atlas Research and MITRE analyzed and presented to the Commission and CMS the public input submissions received.
- MITRE prepared each of the three major deliverables presenting the interim, preliminary, and final recommendations of the Commission.

Public Input. The Commission received 632 responses from a multitude of stakeholders through its website-based feedback form announced publicly by press release. These responses took the form of checkbox indications of interest in the well-being of nursing home residents and staff; 500-character open-ended comments wherein contributors provided their perspective as it aligned to one of the four Commission objectives; and attachments up to five pages long (e.g., formal letters, publications, or other resources). Commission members had the opportunity to review these public inputs, categorized first by objectives and broken down into discussion themes, in a detailed summary report. This summary was later synthesized into a formal briefing to guide the second half of the Commission’s convening schedule. These public inputs urged coordinated federal action to support the enhanced operation of nursing homes; called for the re-prioritization of resident and staff quality of life and safety; and demanded transparent communications and the re-engagement of essential care partners. The Commission used these public inputs to refine their development of actionable recommendations, and to drive the identification of additional relevant actions CMS and its federal partners should take to improve the ongoing COVID-19 response and support of nursing homes. (An analysis of this public input appears in [Appendix E](#) in this report.)

Final Report and Other Deliverables. This final report is based on the Commission’s discussions and recommendations; analysis of public inputs; MITRE’s analysis and clarification of the foregoing; and CMS’s actions to date. MITRE completed most of its research in support of the report as of August 11, in advance of delivering preliminary draft recommendations and action steps to CMS on August 14, noting areas still under Commission discussion. (See [Appendix I](#).) Text and/or endnotes throughout this report reflect where more-recent research or updated

information resulted from input from Commission members or CMS. MITRE notes that CMS and other federal agencies have varied authorities that they have been exercising in a rapidly evolving legislative environment. CMS must work with its federal partners to determine which agency has authority to implement the Commission’s recommendations and action steps.

As MITRE prepared this report, both Commission members and CMS experts had the opportunity to review it in draft form. Commission members were able to comment on any aspect of the report. CMS experts provided technical input by providing comments to MITRE on the following: 1) items that were demonstrated to be factually incorrect or reflect incorrect data, or were objectively wrong based on data and evidence, 2) incomplete or incorrect description of CMS actions, 3) unclear, missing, or incorrect reference to a regulatory provision, 4) incorrect reference to CMS authority, and 5) identification of federal and SLTT government partners necessary to CMS’s implementation of a recommendation or action step.

In addition to this report, as the Commission’s work progressed, CMS Administrator Seema Verma requested that the Commission develop and provide a set of interim, short-term recommendations to inform CMS’s immediate and continuing response to the pandemic. The Commission focused its July 14 convening specifically on this request, and MITRE delivered those short-term recommendations, endorsed by nearly all Commission members, to CMS on July 17. (The text of this memorandum appears as [Appendix G](#) in this report.) CMS noted that some of these interim recommendations reinforced actions CMS already had underway, and that others provided impetus to explore new actions. CMS and its federal partners continued to act as this final report was being prepared.^{10, 11, 12}

Commission Endorsement Matrix

Thirteen members of the Commission endorse this report in full:

- Roya Agahi
- Lisa M. Brown
- Debra Fournier
- Terry T. Fulmer
- Candace S. Goehring
- David C. Grabowski
- Jessica Kalender-Rich
- Marshall Barry Kapp
- Morgan Jane Katz
- Rosie D. Lyles
- G. Adam Mayle
- David A. Nace
- Patricia W. Stone

One member—Eric M. Carlson—does not endorse this report.

Eleven members of the Commission endorse this report with the reservations included on the following table.

Commission Member	Reservations about some specifics for the following theme(s)
Mark Burket	Workforce Ecosystem – Stopgaps for Resident Safety
Michelle Dionne-Vahalik	General reservation (wished for more recommendations framed as “requirements” for nursing home owners and administrators, rather than as “guidance”)
Camille Rochelle Jordan	Workforce Ecosystem – Stopgaps for Resident Safety
Beverley L. Laubert	Testing and Screening Cohorting Workforce Ecosystem – Stopgaps for Resident Safety
Jeannee Parker Martin	Visitation Workforce Ecosystem – Stopgaps for Resident Safety
Lori Porter	Workforce Ecosystem – Stopgaps for Resident Safety Workforce Ecosystem – Strategic Reinforcement
Neil Pruitt, Jr.	Workforce Ecosystem – Stopgaps for Resident Safety
Penelope Ann Shaw	General reservation (opposed to any infringement on resident rights; wished for more accountability for providers to meet standards and to be good stewards of federal dollars)
Lori O. Smetanka	General reservation (wished for more accountability for providers to meet standards and to be good stewards of federal dollars) Workforce Ecosystem – Stopgaps for Resident Safety Workforce Ecosystem – Strategic Reinforcement Technical Assistance and Quality Improvement
Janet Snipes	Workforce Ecosystem – Stopgaps for Resident Safety
Dallas Taylor	Workforce Ecosystem – Stopgaps for Resident Safety

⁴ World Health Organization. (n.d.). *Naming the coronavirus disease (COVID-19) and the virus that causes it*. [https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-\(covid-2019\)-and-the-virus-that-causes-it](https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it)

⁵ Centers for Medicare & Medicaid Services. (2020, April 30). *CMS announces independent commission to address safety and quality in nursing homes* [Press release]. <https://www.cms.gov/newsroom/press-releases/cms-announces-independent-commission-address-safety-and-quality-nursing-homes>

⁶ For this report and the Commission’s work, the term “nursing homes” includes facilities under the purview of CMS, specifically skilled nursing facilities (SNF) that participate in the Medicare program and nursing facilities that participate in the Medicaid program. Many facilities have SNF and Medicaid beds alike. The Commission’s focus did not include nursing facilities under the purview of the Veterans Health Administration.

⁷ Given the novel nature of the virus and rapidly evolving state of understanding of the virus, the Commission was in the realm of “emerging evidence” and “emerging practices” with respect to some areas discussed.

⁸ Centers for Medicare & Medicaid Services. (2020, June 19). *CMS announces membership of independent coronavirus commission for safety and quality in nursing homes* [Press release].

<https://www.cms.gov/newsroom/press-releases/cms-announces-membership-independent-coronavirus-commission-safety-and-quality-nursing-homes>

⁹ MITRE. (2020, July 10). *Independent coronavirus commission for safety and quality in nursing homes launches additional public input option* [Press release]. <https://www.mitre.org/news/press-releases/independent-coronavirus-commission-for-safety-and-quality-in-nursing-homes>

¹⁰ Centers for Medicare & Medicaid Services. (2020, Aug. 25). *Trump Administration Strengthens COVID-19 Surveillance with New Reporting and Testing Requirements for Nursing Homes, Other Providers* [Press release]. <https://www.cms.gov/newsroom/press-releases/trump-administration-strengthens-covid-19-surveillance-new-reporting-and-testing-requirements>

¹¹ Centers for Medicare & Medicaid Services. (2020, Aug. 26). *CMS posts guidance for implementing new testing requirements in nursing homes and labs* [Press release]. <https://www.cms.gov/newsroom/press-releases/cms-posts-guidance-implementing-new-testing-requirements-nursing-homes-and-labs>

¹² Food and Drug Administration. (2020, Aug. 26). *COVID-19 Update: FDA Authorizes First Diagnostic Test Where Results Can Be Read Directly From Testing Card* [Press release]. <https://www.fda.gov/news-events/press-announcements/covid-19-update-fda-authorizes-first-diagnostic-test-where-results-can-be-read-directly-testing-card>

2 Background

2.1 CMS and State Regulation of Nursing Homes

The United States has more than 15,000 nursing homes that care for approximately 1.2 million residents.¹³ Annual spending in 2018 on nursing homes¹⁴ was approximately \$170 billion, with Medicare spending approximately \$38 billion and Medicaid spending approximately \$50 billion.¹⁵ Nursing homes provide skilled nursing care and related services for residents who require medical or nursing care and rehabilitation services for people with injuries, disabilities, and illnesses.¹⁶ For this report and the Commission’s work, the term “nursing homes” includes facilities certified to participate under the Medicare and Medicaid programs, specifically skilled nursing facilities (SNF)¹⁷ that participate in Medicare and nursing facilities (NF)¹⁸ that participate in Medicaid only, but not assisted living facilities. Although some may use the terms “skilled nursing facility” and “nursing facility” interchangeably (along with “long-term care facility”), and some facilities are certified/participate as both NFs and SNFs,¹⁹ clinical and coverage differences exist between the two.^{20, 21} Nursing homes span in size and organizational structure from small, single-facility nonprofits to facilities that are part of regional or national chains to nursing homes that are integrated into their local or regional health system. Nursing homes are additionally subject to state regulation, as further discussed in this section. The Commission focused on CMS actions, which includes actions that could affect both SNFs and NFs; state actions were beyond its scope.

Since nursing homes are subject to both state and federal authorities, they must navigate a patchwork of regulations and guidance. Federal statutory authority for CMS oversight of long-term care facilities and requirements for participation reside in sections 1819 and 1919 of the Social Security Act (the Act) for Medicare- and Medicaid-participating nursing homes, respectively.²² These authorities work in tandem to ensure the safety and quality of care; provide a comprehensive plan of care, training, licensure, and competency of staff; and protect residents’ rights, such as freedom of choice and freedom from restraints, in Medicare- and/or Medicaid-participating facilities. These sections also permit the Department of Health and Human Services (HHS) to establish any additional requirements relating to the health, safety, and well-being of SNFs and NFs as its Secretary finds necessary. CMS has the authority to penalize facilities that are in violation of these requirements. Although state nursing home regulations vary, and some states may establish more stringent requirements than those imposed nationally, CMS’s role as a national regulator places it in an important position to ensure safety and quality in nursing home care around the country.

In addition to federal laws and regulations, each state adopts its own legislative requirements for the operations, governance, and quality assurance in nursing homes and assisted living facilities alike.²³ States have the authority to license healthcare practitioners and facilities.²⁴ States may also have separate laws and regulations governing all nursing homes in the state (i.e., not just those participating in Medicare and Medicaid) that may exceed federal requirements, including state enforcement actions.²⁵ State surveys/site visits serve a key monitoring function in the nursing home ecosystem.

To prepare for public health emergencies, CMS has acted to ensure that Medicare and Medicaid providers and suppliers of all types adhere to certain emergency preparedness requirements. For example, CMS issued a final rule outlining a “comprehensive, consistent, flexible, and dynamic regulatory approach to emergency preparedness and response”²⁶ for a wide variety of healthcare providers and suppliers that participate in Medicare and Medicaid, including nursing homes. That final rule specified emergency-preparedness requirements for long-term care facilities, which it codified at 42 CFR § 483.73 (Emergency Preparedness regulation). These regulations generally align with those emergency preparedness requirements that CMS has adopted for hospitals, with an additional requirement for long-term care facilities to track the locations of residents and staff during and after emergencies. These requirements ensure that long-term care facilities develop and implement emergency-preparedness policies and procedures on topics such as providing sufficient food, water, medical, and pharmaceutical supplies for staff and resident during an emergency; communication plans with contact information for staff, vendors, residents’ physicians, other facilities, and volunteers; and training and testing programs provided at least annually. Other requirements ensure that facilities implement emergency and standby power systems and allow facilities that are part of integrated healthcare systems to participate in unified and integrated emergency-preparedness policies developed by their healthcare systems. Long-term care facilities must establish and maintain these plans in order to participate in the Medicare and Medicaid programs. CMS works closely with state surveyors to enforce these regulations and to ensure that long-term care facilities maintain appropriate emergency-preparedness plans.

The interaction of federal and state authorities within the Medicaid program often involve requests for Medicaid waivers under section 1915, 1932, and 1115 of the Act. Medicaid State Plan Amendments also provide important state-driven activities subject to federal approval. These authorities are intended to allow flexibility in the delivery of Medicaid benefits at the state level, including changes to eligibility, delivery system (managed care), benefits, and value-based payments beyond what is normally permitted (or for costs not otherwise matchable) under the Medicaid statute.²⁷

In relation to public health emergencies, the Secretary is authorized under section 1135 of the Act to temporarily waive or modify Medicare, Medicaid, and Children’s Health Insurance Program (CHIP) requirements to meet the needs of a natural disaster or public health emergency.²⁸ Ordinarily, providers in each state are responsible for submitting a formal request in writing to a dedicated inbox, and for notifying their CMS Location of the pending request; CMS may also implement specific waivers or modifications under the 1135 authority on a “blanket” basis, upon a determination that all similarly situated providers in the emergency area need such a waiver or modification.²⁹

On March 13, CMS announced that in addition to reviewing specific provider requests for 1135 waivers, it would activate blanket waivers nationwide to ease requirements for providers impacted by the COVID-19 national emergency.³⁰ CMS announced the blanket waivers were to take effect retroactively from March 1 through the end of the emergency declaration. Although Section 1135 blanket waivers apply to a broad spectrum of providers, CMS enacted blanket waivers specifically for nursing homes, including but not limited to waiver of Pre-Admission Screening and Annual Resident Review; waiver of residents’ rights to participate in person in

resident group activities; modification to the nurse aide training requirements; waiver of discharge planning requirements, and modifications to the scope of Quality Assurance and Performance Improvement (QAPI) reporting requirements.³¹ As of August 19, CMS has also approved 118 state-specific requests (with several states having multiple approved requests) for 1135 waivers for various flexibilities to ease challenges with healthcare delivery for providers during the pandemic.³² Generally, these state waiver approvals are retroactively effective to March 1, and will terminate upon termination of the public health emergency.³³

2.2 SARS-CoV-2 Exposure, Spread, and Mitigation in Nursing Homes

According to the Centers for Disease Control and Prevention (CDC), the risk for severe illness from SARS-CoV-2 infection increases with age; adults aged 85 or older are at highest risk.³⁴ Additionally, people with some underlying medical conditions (e.g., cancer, chronic kidney disease, chronic obstructive pulmonary disease, immunocompromised state, obesity, serious heart conditions, sickle cell disease, or Type 2 diabetes mellitus) face increased risk of severe illness when infected with the virus.³⁵ These risks are heightened by the congregate nature and relatively frequent infections among residents in long-term care facilities, estimated between 1 and 3 million serious infections per year in nursing homes, SNFs, and assisted living facilities.^{36, 37}

The virus's disproportionate effect on nursing home resident and staff populations is due in part to the way that the virus spreads. Similar to other human coronaviruses and respiratory viruses, SARS-CoV-2 appears to transmit between humans through expulsion of respiratory droplets from an infected individual.³⁸ Talking, coughing, singing, exercising, and other activities can cause respiratory droplets with viral particles to be shed into the immediate proximity of the infected person.^{39, 40, 41} The most effective way to prevent the spread of the virus is to limit the frequency and duration of close physical contact between an infected individual and an uninfected individual.⁴² As a result, effective methods to reduce this spread include physical distancing at a community level and physical separation within nursing homes to limit contact among individuals.⁴³ This strategy, however, is problematic in care facilities where vulnerable people are kept in close quarters—and are not only permitted, but also encouraged, to socially interact with one another. When physical distancing is not entirely possible, cohorting presents another mitigation strategy.^{44, 45} Cohorting is the process of locating individuals with the same condition in the same space, with the intent of reducing or eliminating interaction between infected persons with uninfected persons.⁴⁶ Cohorting could help reduce the spread of the virus; it has shown to be effective both historically and during recent infectious outbreaks.⁴⁷

[As discussed in this report](#), however, cohorting is often problematic for residents' social and emotional health. Preventing the spread of this virus through physical distancing may lead to unintended consequences for residents. For example, limiting potential exposure to the virus through physical isolation has left family members, legal surrogates, and others unable to observe the status of residents due to restrictive visitation policies. Public input submitted to the Commission expressed fears about, and examples of, abuse and neglect—and missed opportunities to identify or intervene. State survey data in the period leading up to the pandemic showed that “most facilities (80%) received a deficiency related to resident quality of life or care, and 37% received an abuse/neglect/exploitation deficiency.”⁴⁸ Visitation restrictions

implemented for infection control have elevated demand on state ombudsman programs and placed attention on the reduced scale and scope of state inspection and survey activity during this time.^{49, 50} [As discussed in this report](#), assisting nursing homes, residents, and families to find an avenue for safe visitation is a high priority that is contingent on the availability of rapid testing and results and PPE for visitors.

As of August 13, 8% of all U.S. COVID-19 disease cases and 41% of all U.S. COVID-19 disease deaths are linked to nursing homes.

2.3 COVID-19 and Nursing Home Data

Since SARS-CoV-2 was first detected in Washington State on January 20,⁵¹ nursing homes have endured high rates of infection, and related morbidity and mortality among residents.⁵² As of August 9, almost 12,000 facilities nationwide have reported COVID-19 disease cases among their residents and staff—including 188,954 resident cases—which have led to more than 48,215 COVID-19 related deaths among residents. The virus has affected nursing homes disproportionately: reported data through August 13 show that 8% of COVID-19 cases and 41% of COVID-19 deaths in the United States have occurred among residents and staff.⁵³

CMS and other federal and SLTT agencies have taken steps to address this crisis. For example, CMS released a series of guidelines targeted at reducing the impact of COVID-19 on nursing homes and other long-term care facilities, including guidance related to visitor restrictions, infection control guidelines, and designating separate facilities for COVID-positive residents and COVID-negative residents. (See [Appendix D](#) for a list of CMS actions taken to date.) Additionally, on April 19, CMS announced new reporting requirements requiring nursing homes to report cases of COVID-19 directly to the CDC.⁵⁴

Figure 1 shows the location of nursing homes with identified COVID-19 resident cases.⁵⁵

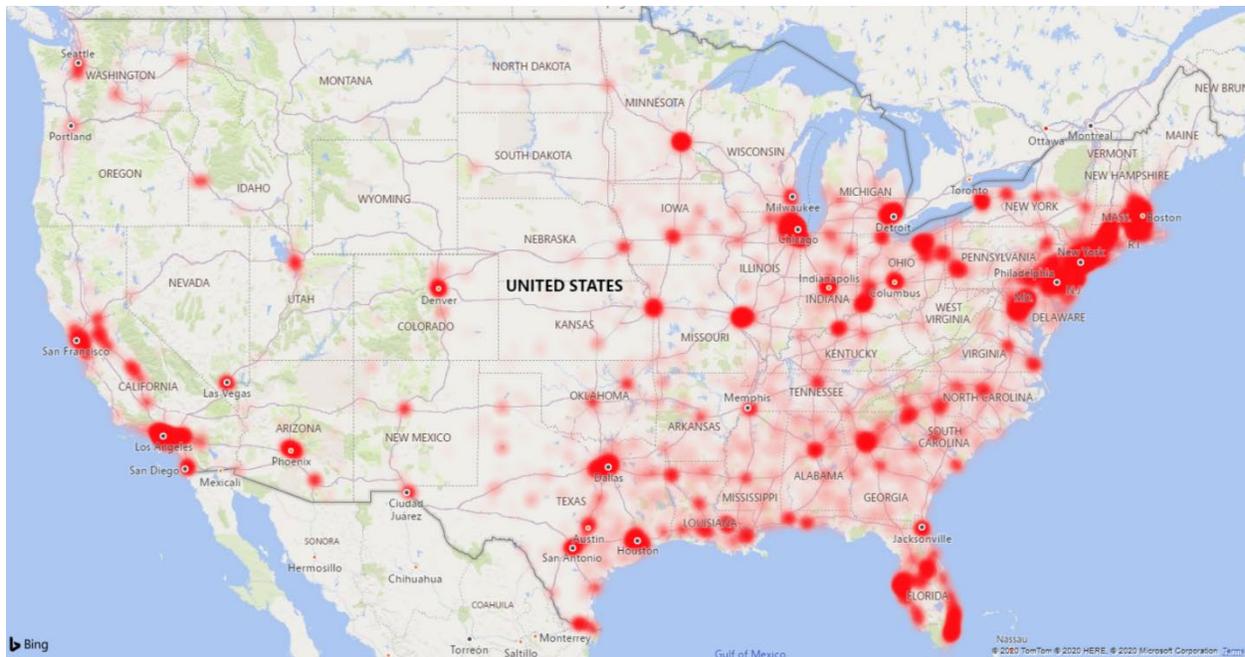


Figure 1: Nursing Home COVID-19 Resident Confirmed Cases Heat Map developed from CMS Nursing Home COVID-19 Public File, Submitted Data as of Week Ending 8/9/2020

A variety of data sources are available to describe and assess the impact of COVID-19 on nursing homes. At the federal level, CMS and CDC use the National Healthcare Safety Network (NHSN) to collect standardized COVID-19 data from owners and administrators across the country. CMS finalized new reporting requirements to collect this data starting in May.⁵⁶ Because reporting COVID-19 cases and deaths prior to this time was optional, counts from January 1 through May 24 are likely to be inconsistent across states. Nevertheless, this approach established a central repository for ongoing collection of data about facility characteristics, occupied beds, number of residents and staff with suspected and confirmed COVID-19, number of residents and staff deaths due to COVID-19, staff shortages, supply of PPE, and other details.

At the state level, the scope and availability of nursing home data related to COVID-19 is varied and often not directly comparable to the federal data.⁵⁷ Some states made detailed data on cases and deaths publicly available early on; others did not.⁵⁸ Various entities have also summarized or analyzed state-level data on nursing homes (or long-term care facilities), such as AARP,⁵⁹ the Kaiser Family Foundation,⁶⁰ and the *New York Times*.⁶¹

Although the variability in these data is challenging, it is nonetheless important to consider how to best use the available state data, in conjunction with the federal data, to gain the greatest insights. Each data source must be evaluated individually to understand how the individual elements derived from that source are defined; for example, CMS provided a data dictionary for the Nursing Home COVID-19 Public Use File (PUF) based on the NHSN data that describes each of the variables in the dataset.⁶² A rapid consultation guide created by the National Academies of Sciences, Engineering, and Medicine Societal Experts Action Network (NASEM SEAN) that summarizes benefits and drawbacks of selected measurements is an example of

efforts to develop standard guidance in this area.⁶³ [Appendix H](#) provides additional information about data limitations related to nursing homes.

2.4 Systemic Problems in Long-Term Care

Several long-term, systemic problems underline the difficulties of preventing and treating COVID-19 in nursing homes. In exchanges about current and future responses to COVID-19 (and future infectious disease outbreaks), Commission members discussed at length the systemic issues exacerbated by the pandemic. Prior reports have documented these issues; chief among these challenges are related to financing, fiscal accountability, facility design, workforce, governance/management, technology, data, and research.⁶⁴ Short-term solutions cannot be found in isolation from the pressing need for systemic improvements in the long-term care sector; these long-standing systemic issues thus became the lens through which the Commission approached its work.

Delivery Systems

In its 2013 Report to Congress, the Commission on Long-Term Care (2013 Commission) described fragmented care delivery models for individuals in nursing homes, with little coordination between care settings.⁶⁵ The needs of individuals and families are subordinated to the systems in which those individuals and families engage. Funding streams and setting specifications (e.g., SNF, rehabilitation, long-term care) may encumber person-centered and person-driven care, and can deprioritize residents' individual choices.

In addition, owners and administrators are paid under several different systems (i.e., private and public; and federal, state, and local governments). These fragmented funding streams, featuring widely varying rates and myriad regulations, further exacerbate the currently fragmented delivery system. Thus, even experts in nursing homes experience difficulty when striving to understand which payer is responsible for which services and solutions.

Workforce and Other Limited Resources

The 2013 Commission emphasized a recurring issue in most discussions of nursing homes: Homes are hampered by too few staff, who are paid too little for physically and emotionally taxing work. Additionally, little room exists for these professionals to advance in their careers, and they suffer from a lack of meaningful benefits.⁶⁶ As a result, challenges in workforce recruitment and retention are compounded year-over-year, as workforce shortages persist with the older population increasing. Without qualified staff, nursing homes find it difficult to meet residents' regular needs—let alone those that arise in times of crisis.

Along with shortages in the workforce, some nursing home owners and administrators are limited in the resources at their disposal—hampering responses to emergencies regardless of whether they are natural disasters or infectious disease outbreaks. When crises arise, owners and administrators frequently do not have necessary training, equipment, or staff to respond. Often, nursing homes may be deemed lower-priority facilities for assistance from government sources in comparison to acute care settings.⁶⁷ As a result, emergencies stress an already precarious care system.

In the Wake of a Pandemic, Balancing Resident and Staff Safety and Well-Being

These systemic issues have become especially pointed during the COVID-19 pandemic. Rigorous infection-control practice and treatment needs require that residents that test positive for COVID-19 may need to be transferred to new locations within their nursing home, to other sites, and in and out of hospitals. In the early days of the pandemic, transitions at times were abrupt, and the resident and family had no prior awareness that such a transition might occur.⁶⁸ In the future, when a nursing home contends with a widespread outbreak, rapid transitions may still be indicated.⁶⁹ When transitions are not well-communicated, the result may be that care is not coordinated or handoffs are missed. The resident and family suffer from the trauma that relocation and/or isolation may cause—from the possible decline in care quality, as well as from missed opportunities for resident-centered shared decision-making.

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

The Commission members offered expertise as seen through these lenses of systemic challenges in delivery, workforce, and resources; these fundamental and long-standing challenges informed their recommendations and lessons learned. As one Commission member pointed out, “Nursing homes were not designed with infectious disease control in mind.” Many members noted that stopping the spread of infectious diseases in nursing homes cannot be accomplished without immediately addressing these long-standing issues.

2.5 Guiding Principles in Relation to Safety and Quality of Nursing Home Residents

These long-standing, systemic issues informed not only the development of the Commission’s recommendations, but also shaped guiding principles for their implementation. Commission members were aligned in their belief that CMS would be most effective in implementation of the recommendations and associated action steps if guided by two overarching principles: elevating person-centered and person-driven care; and increasing organizational capacity to improve safety and quality.

Elevating Person-Centered and Person-Driven Care

Despite regulatory recognition of person-centeredness, resident goals, values, and needs often are treated as important—but not central—considerations.⁷⁰ Elevating person-centered care requires that care providers first ask what is best for the resident, and ensures they are active participants in decision-making about their care. Where residents are unable to actively participate in these decision-making processes, and/or when they would like additional support, legal surrogates should likewise be assured of an equal place on the care team. These considerations remain of paramount importance, even during a pandemic and when planning for future emergencies.

Further, person-driven care means empowering residents to take the lead in decision-making about their care, and to identify their desired health outcomes. As nursing home administrators implement policies impacting residents, they should do so in consultation with the resident and, ideally, driven by the resident (or their legal surrogate in situations when residents are unable to drive these decisions). Given that the nursing home is many residents' home—not a temporary care setting—their inclusion, at least on a representative level, in emergency plan creation, and their engagement at an individual level during implementation is pragmatic and reasonable. As owners and administrators consider how to best implement rigorous infection prevention and control practices within their facilities in the months to come, they must empower residents as partners in finding person-centered solutions that ensure connections with their essential care partners, legal surrogates, families, and advocates.

Increasing Organizational Capacity to Improve Safety and Quality

During the pandemic and everyday, nursing home staff are responsible for the care and protection of some of the most vulnerable populations in the nation. The safety and quality of life needs of residents are complex and diverse, and require mindful decision-making and effective processes in order to be met.

Mindful decision-making is only possible when the workforce feels safe, prepared, and respected for the meaningful work they do. They need to work in facilities compliant with Occupational Safety and Health Administration (OSHA) regulations; they need timely access to the right training, equipment, and technology; and they need to be compensated at a level commensurate with the intensity of the care they provide. These needs must be accompanied by a multi-faceted financing approach that involves securing and distributing federal emergency funding relief and longer-term appropriations, reforming Medicaid and Medicare reimbursement rates, and allocating wage pass-throughs.

Employing effective processes requires that oversight bodies at federal and SLTT levels deliver clear, concise, timely, transparent, and evidence-based guidance and instruction for compliance, as well as streamline reporting requirements. Moreover, nursing home owners and administrators, along with their oversight bodies, share responsibility for ensuring that required processes for operation are implemented and continuously improved as new learnings emerge about the pandemic.

As such, CMS actions in response to the pandemic should have the intention of increasing organizational capacity so that nursing home staff fulfill their responsibilities related to the care and protection of residents. Increasing organizational capacity can involve both effective

oversight and enforcement but also leveraging the resources and insights gleaned from a national level perspective of the pandemic and disseminating them to others at the ground level.

Other Principles at Play – Providing Funding and Ensuring Accountability

The Commission discussed other principles, as reflected directly in some of the recommendations and associated actions. Some members voiced strongly that CMS should make no unfunded mandates: if CMS implements the recommendations and actions steps in this report, it must do so in a way that ensures funding mechanisms are in place to support them.

Other members stressed the criticality of CMS and its federal partners in ensuring accountability and appropriateness for how emergency and other funds are spent, now and in the future, by owners and administrators. These members underscored CMS’s oversight and enforcement role and voiced concerns if CMS implemented recommendations without plans in place to monitor and ensure funds were applied for their intended purpose.

¹³ Kaiser Family Foundation analysis of 2019 Certification and Survey Provider Enhanced Reports (CASPER) data. <https://www.kff.org/state-category/providers-service-use/nursing-facilities/> Centers for Disease Control and Prevention. (2019). *Nursing home care*. <https://www.cdc.gov/nchs/fastats/nursing-home-care.htm>; *Not forgotten: Protecting Americans from abuse and neglect in nursing homes: Hearings before the Senate Committee on Finance*, 116th Cong. (2019) (testimony of David C. Grabowski). <https://www.finance.senate.gov/imo/media/doc/Grabowski%20Senate%20Finance%20testimony%20FINAL.pdf>; Homeland Infrastructure Foundation-Level Data- Public Health. (2020). *Nursing homes* [Map]. <https://hifid-geoplatform.opendata.arcgis.com/>

¹⁴ In this instance, nursing homes refers to nursing homes and continuing care requirement communities alike, as is the case with the CDC data from which the datapoint is drawn.

¹⁵ Centers for Medicare & Medicaid Services. (2019, November 26). *National health expenditures data* [Data set]. <https://www.cms.gov/files/zip/national-health-expenditures-type-service-and-source-funds-cy-1960-2018.zip>. See also Grabowski cited at note 3.

¹⁶ Nursing Homes. (n.d.). in *Nursing Home Compare Glossary*. <https://www.medicare.gov/NursingHomeCompare/Resources/Glossary.html>

¹⁷ Section 1819(a) of the Social Security Act [42 U.S.C. 1395i-3(a)] defines skilled nursing facilities (SNFs) as “...an institution (or distinct part of an institution) which (1) is primarily engaged in providing to residents (A) skilled nursing care and related services for residents who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and is not primarily for the care and treatment of mental disease; has in effect a transfer agreement...”; and meets other SNF requirements described therein.

¹⁸ Section 1919(a) of the Social Security Act [42 U.S.C. 1396r(a)] defines nursing facilities as “...an institution (or a distinct part of an institution) which (1) is primarily engaged in providing residents (A) skilled nursing care and related services for residents who require medical or nursing care, (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or (C) on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, and is not primarily for the care and treatment of mental diseases; (2) has in effect a transfer agreement...with one or more hospitals...” and (3) meets other NF requirements described therein.

¹⁹ Most SNFs (more than 90 percent) are dually certified as SNFs and nursing homes. Medicare Payment Advisory Commission. (2020). *Chapter 8, skilled nursing facility services* (Report to the Congress: Medicare Payment Policy). http://www.medpac.gov/docs/default-source/reports/mar20_medpac_ch8_sec.pdf?sfvrsn=0

²⁰ SNFs provide short-term skilled nursing or rehabilitation care after an individual is discharged from the hospital, also known as post-acute care. Medicare covers skilled nursing care in a SNF for up to 100 days per spell of illness, after a medically necessary inpatient hospital stay of at least three days. (A spell of illness begins with the first day of

a hospital or SNF stay and ends when there has been 60 consecutive days during which an individual was not in a hospital or a SNF). For beneficiaries who qualify for a covered stay, Medicare pays 100 percent of the payment for the first 20 days of the spell of illness. Beginning with day 21, beneficiaries are responsible for copayments through day 100 of the covered stay. Medicare does not cover custodial care if that is the only type of care needed. Custodial care is care that helps the resident with usual daily activities, like getting in and out of bed, eating, bathing, dressing, and using the bathroom. It may also include care that most people do themselves, like using eye drops, oxygen, and taking care of colostomy or bladder catheters. See Centers for Medicare and Medicaid Services. (2019). *Medicare coverage of skilled nursing facility care*. <https://www.medicare.gov/Pubs/pdf/10153-Medicare-Skilled-Nursing-Facility-Care.pdf>. The Medicare SNF benefit covers skilled nursing care, rehabilitation services, and other goods and services. Medicare Payment Advisory Commission. (2019). *Skilled nursing facility services payment system*. http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_19_snf_final_sec.pdf?sfvrsn=0

²¹ NFs provide 24-hour long-term medical and skilled nursing care, rehabilitation, or health-related services to residents. That care is intended to sustain the wellness level of a person who does not require hospital level care but does require nursing care due to a mental or physical condition and cannot remain at home. Medicaid is the primary payer of long-term care including 55 billion in 2015 for nursing homes covering approximately 60 percent of NF residents in the United States. Eiken et. al. (2017, April 14). *Medicaid expenditures for long-term services and supports (LTSS) in FY 2015*. <https://www.medicaid.gov/sites/default/files/2019-12/Itssexpendituresffy2015final.pdf>. See also Centers for Disease Control and Prevention. (2016). *Long-term care providers and services users in the United States: data from the national study of long-term care providers, 2013–2014*. https://www.cdc.gov/nchs/data/series/sr_03/sr03_038.pdf.

Medicaid coverage of NF services is available only for services provided in a nursing home licensed and certified by the state survey agency as a Medicaid NF. Centers for Medicare and Medicaid Services. (n.d.). *Nursing facilities*. <https://www.medicaid.gov/medicaid/long-term-services-supports/institutional-long-term-care/nursing-facilities/index.html>. NF services are required to be provided by state Medicaid programs for individuals age 21 or older who need them; services for individuals under age 21 is a separate, optional, Medicaid service. However, in practice there is no distinction between the services because all states provide both services. States define the parameters of NF services and NF level of care criteria in their Medicaid state plan, which may also specify limitations to each service.

²² Sections 1819 and 1919 of the Social Security Act. For the most part, these statutes mirror each other for consistency across Medicare- and Medicaid-participating facilities with a few special considerations for the scope of services for SNFs under Medicare.

²³ University of Minnesota School of Public Health, Division of Health Policy Management. (2012, March 19). *Nursing home state regulations by state*. http://www.hpm.umn.edu/nhregsplus/NHRegs_by_State/By%20State%20Main.html

²⁴ Walsh, K. (2001, December). HEALTH AFFAIRS VOL. 20, NO. 6: CHRONIC CARE IN AMERICA Regulating U.S. Nursing Homes: Are We Learning From Experience? <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.20.6.128>

²⁵ *Id.*

²⁶ *Medicare and Medicaid Programs; Emergency Preparedness requirements for Medicare and Medicaid Participating Providers and Suppliers*. 81 Fed. Reg. 63860 (September 16, 2016).

<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/>

²⁷ Artiga, S., Hinton, E., Rudowitz, R., & Musmumeci, M. (2017, January 31). *Current flexibility in Medicaid: An overview of federal standards and state options*. Kaiser Family Foundation. <https://www.kff.org/report-section/current-flexibility-in-medicaid-issue-brief/>

²⁸ 42 U.S.C. § 1320b–5 (2010).

²⁹ Medicaid and CHIP Payment and Access Commission (MACPAC). (2020, March). *Section 1135 Waivers*. <https://www.macpac.gov/subtopic/section-1135-waivers/>

³⁰ Centers for Medicare & Medicaid Services. (2020, March 13). *CMS takes action nationwide to aggressively respond to coronavirus national emergency* [Press release]. <https://www.cms.gov/newsroom/press-releases/cms-takes-action-nationwide-aggressively-respond-coronavirus-national-emergency>

³¹ Centers for Medicare & Medicaid Services. (2020, July 7). *Long Term Care Facilities (Skilled Nursing Facilities and/or Nursing Facilities): CMS Flexibilities to Fight COVID-19* <https://www.cms.gov/files/document/covid-long-term-care-facilities.pdf>

³² Centers for Medicare & Medicaid Services. (Updated 2020, August 19) *Federal Disaster Resources (Waiver List)* <https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/federal-disaster-resources/101346>

³³ *Id.*

- ³⁴ Centers for Disease Control and Prevention. (2020, August 16). *Coronavirus disease 2019 (COVID-19), older adults*. <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/older-adults.html>
- ³⁵ Centers for Disease Control and Prevention. (2020, August 14). *Coronavirus disease 2019 (COVID-19), people with certain medical conditions*. <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html>
- ³⁶ Centers for Disease Control and Prevention. (2020, June 22). *Nursing homes and assisted living (long-term care facilities [LTCFs])*. <https://www.cdc.gov/longtermcare/index.html>
- ³⁷ Centers for Disease Control and Prevention. (2020, June 25). *Nursing homes & long-term care facilities*. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>
- ³⁸ Centers for Disease Control and Prevention. (2020, June 16). *How COVID-19 spreads*. <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-covid-spreads.html>
- ³⁹ *Ibid.*
- ⁴⁰ Hamner, L., Dubbel, P., Capron, I., Ross, A., Jordan, A., Lee, J., Lynn, J., Ball, A., Narwal, S., Russel, S., Patrick, D., & Leibrand, H. (2020). *High SARS-CoV-2 attack rate following exposure at a choir practice — Skagit County, Washington, March 2020* (Report 2020; 69:606–610). Center for Disease Control and Prevention. <https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e6.htm>
- ⁴¹ Jang, S., Han, S., & Rhee, J. (2020). Cluster of coronavirus disease associated with fitness dance classes, South Korea. *Emerging Infectious Diseases*, 26(8), 1917-1920. <https://dx.doi.org/10.3201/eid2608.200633>
- ⁴² Centers for Disease Control and Prevention. (2020, July 31). *How to protect yourself & others*. <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html>
- ⁴³ Centers for Disease Control and Prevention. (2020, July 15). *Social distancing*. <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/social-distancing.html>
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- ⁶⁸ Goodman, C. K. (2020, May 13). *Florida transferring nursing home residents with coronavirus into hospitals*. South Florida Sun Sentinel. <https://www.sun-sentinel.com/coronavirus/fl-ne-coronavirus-nursing-homes-mass-transfers-20200513-vdpc2txp7jeztepngt3dsk3eve-story.html>
- ⁶⁹ MITRE-developed, derived from Commission discussion and/or public input.
- ⁷⁰ Although current CMS regulations (42 C.F.R. § 483.10) state that “person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives,” and recognize the resident’s right to participate in the development and implementation of a person-centered plan of care as a resident right, resident advocates argue these regulations are vague and difficult to enforce.

3 Themes, Recommendations, Action Steps, and Analysis

The Commission emerged from its convenings with 27 recommendations, with accompanying action steps, and organized into ten themes. These themes intersect the Commission’s four objectives, and reflect responses to the:

- Ongoing supply and affordability dilemmas related to testing, screening, and personal protective equipment (PPE)
- Tension between rigorous infection control measures and quality of life issues that exist in cohorting and visitation policies
- Call for transparent and accessible communications with residents, their representatives, and loved ones, and the public
- Urgent need to train, support, protect, and respect direct-care providers
- Stressed and outdated infrastructure of many nursing-home facilities
- Opportunities to create and organize guidance to owners and administrators that is more actionable (and data from nursing homes more meaningful for action and research)
- Insufficient funding for quality nursing home operations, workforce performance, and resident safety.

Organized by theme, this section presents the primary problems identified by the Commission, outlines CMS responses as of early August (unless otherwise noted) and emerging evidence related to the theme; and presents the Commission’s principal recommendations and related action steps. Each theme section closes by documenting the Commission’s endorsements. The intent is that CMS would implement each principal recommendation in conjunction with its associated action steps.

The icons, as provided as a sample in Figure 2, respectively, provide a visual indication of the association between each theme and the four objectives of the Commission, and between the theme and the volume of public input received on that theme. The icons appear on the first page of each Theme subsection.

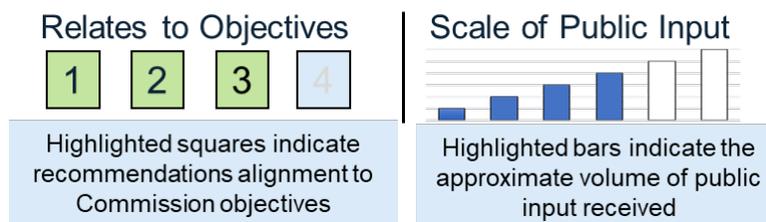


Figure 2. Sample Icons Aligning Themes to Objectives and Public Input Volume.

3.1 Testing and Screening



The Commission identified five primary problems associated with testing and screening.⁷¹

1. National and regional testing and screening supply shortages continue, and nursing homes have not been prioritized.
2. Extended wait times for testing results prevent meaningful infection control.⁷²
3. Funding gaps prevent owners and administrators from implementing staff screening and testing in accordance with existing CMS and CDC guidance.⁷³
4. Healthcare personnel may lack adequate training to administer tests properly, as well as sufficient resources and time to screen visitors and staff in accordance with CDC recommendations.
5. A national strategy that specifically prioritizes nursing home test accessibility with rapid turnaround time does not yet exist, which contributes to a backlog of screening tests and hampered nursing homes in responding to outbreaks in real-time.

Response to Date and Emerging Evidence

CMS Actions to Date. Starting in March, CMS and CDC released iterative guidance about screening and testing residents, staff, and visitors.^{74, 75} On July 22, CMS announced an additional \$5 billion from the Provider Relief Fund (including 15,000 testing devices) to support testing, and that it would begin requiring (rather than recommending) weekly staff testing in states with a 5% positivity rate or greater.⁷⁶ The Office of the Assistant Secretary for Health (OASH) oversees test distribution.

Commission Member Discussions. Commission members focused on this theme during their first convening on July 1, returning to it throughout their convenings. When asked to prioritize immediate, short-term actions, this theme was among the Commission’s top priorities.

Discussion noted challenges that owners and administrators face with paying for and acquiring testing and screening supplies.^{77, 78}

They stressed the need for rapid and appropriate testing of staff, residents, and visitors, to mitigate potential spread, leading them to recommend a targeted approach to ensure adequate supplies are available.⁷⁹ The Commission focused on the importance of funding for staff screening and testing in

response to the exclusion of funding for frontline worker return-to-work testing from the CARES Act.⁸⁰ Members also noted the importance of visitor testing. They noted that access to testing supplies alone was insufficient when unaccompanied by the ability to rapidly receive results. Some Commission members observed the risks and issues raised by error rates in the rapid

"Major issue is that testing [and rapid results are] not readily available. There is a shortage and laboratories are redirecting priorities out of the state, leading to a turnaround time of more than a week."

-Commission Member

antigen test results, as well as additional issues arising in some states where state public health authorities may require nursing homes to use more-sensitive tests than the test technology provided by CMS and other HHS components.⁸¹ Other members underscored that CMS must not enforce testing requirements unless all facilities have the testing equipment they need, as well as sufficient and sustained access to supplies to use the equipment. Further, these members asserted that in any enforcement scheme, CMS must not punish providers for issues beyond their control (e.g., lack of available supplies or lab capacity in delivering timely test results). Other members emphasized the need for CMS to establish clear requirements related to testing according to best practices, and a mechanism to ensure that those requirements are being followed. With respect to the provision of testing supplies, a member noted that all testing supplies should be paired with clear guidance regarding protocols for implementing both surveillance and outbreak response. (For example, point of care antigen tests may be used for screening staff and visitors on a weekly basis in a non-outbreak setting. Antigen tests may be used to rapidly identify positive residents with symptoms; in an outbreak setting all negative antigen tests should be followed by a confirmatory molecular (PCR) test due to the high potential false negative rates of antigen tests.)

Public Input. Public comments expressed the need for more widely available and rapid testing and screening to support cohorting, along with visitation policies that can enhance social and emotional health as well as critical workforce availability. Submitters also noted the importance of increasing the protection of existing workforce members, as many facilities are already understaffed and struggle to recruit. Enhanced testing and screening were widely mentioned as the best solution to ensure the efficient use of staff across facilities, especially in the case of staff supporting multiple sites.

Emerging Evidence. See [Appendix C](#) for discussion of the emerging evidence and regulatory background.

Principal Recommendation and Action Steps

Principal Recommendation 1A: Immediately develop and execute a national strategy, coordinating with federal partners and SLTT authorities, for testing and delivering rapid turnaround of results (i.e., results in less than 24 hours) in nursing homes, in combination with CDC-recommended screening protocols. Allow nursing home owners and administrators to tailor the strategy based on community prevalence and resource availability in partnership with federal and SLTT authorities.

Action Steps

Testing:

- Ensure that nursing homes are prioritized to receive testing and screening supplies, and rapid turnaround of test results, based on the prevalence of COVID-19 in facilities and in the surrounding community.
[Collaborate with federal partners; SLTT]
- Develop a central point for coordinating distribution among federal partners of testing kits (including molecular point-of-care testing) and adequate supplies. Ensure that testing with sufficient supplies is made available, based on the prevalence of COVID-19 in the

area, in one quarter, one half, three quarters, and all of the nation’s nursing homes—by Oct. 1, Nov. 1, Dec. 1, and Jan. 1, 2021, respectively.

[Collaborate with federal partners; SLTT]

- Identify and work to achieve funding mechanisms for nursing home staff to ensure nursing home capability to conduct baseline and iterative testing of staff and residents alike. In the interim, seek access to additional funding from the HHS Public Health and Social Services Emergency Fund to ensure that nursing homes are able to support the scale of screening and testing required for effective operations.
- Ensure approved rapid tests (e.g., those approved under the NIH RADx initiative) are providing accurate results.
[Partner with CDC, the Food and Drug Administration (FDA), the National Institutes of Health (NIH), the Agency for Healthcare Research and Quality (AHRQ), and other federal agencies as needed]
- Provide a list of recommended tests for nursing home use.
[Collaborate with FDA]
- Provide, with federal partners, training for all rapid testing machines and, as appropriate, waive current Clinical Laboratory Improvement Amendments (CLIA) limitations to permit on-site testing.⁸² Accompanying instructions should note limitations of rapid tests in terms of reliability and accuracy.
[Collaborate with federal partners]
- Develop a decision tree that incorporates recommendations from Nursing Home Reopening Recommendations for State and Local Officials, QSO-20-30-NH (May 18, 2020)⁸³ and that communicates the most appropriate testing strategy for residents, staff, and visitors for baseline and iterative testing. This decision tree must be tailored for community prevalence and other risk factors (e.g., staff travelling between nursing homes, residents receiving offsite care including dialysis) to encourage effective planning and intervention. It should explain what to do (e.g., cohorting, observation, transfer, additional testing) when a resident or staff member: (1) is exposed to an individual(s) known to have COVID-19; (2) is presumptively positive; (3) confirmed positive; or (4) refuses testing.⁸⁴ If a resident refuses testing under 42 CFR § 483.10(c)(6),⁸⁵ require quarantine of the resident for up to 14 days pursuant to the waiver of 42 CFR §483.10 (e)(6)⁸⁶ and (7),⁸⁷ and document the reasoning and action in the resident’s record.

Screening:

- Recommend, with support of CDC and FDA, and provide funding for, technology-based solutions that can improve daily screening processes and allow staff to focus on direct resident care. Include recommendations for web and phone-based applications that can quickly capture and assess screening questions for each person entering a nursing home without the use of staff input or assistance. Develop recommendations for physical screening technologies (e.g., touchless temperature devices). Update recommendations as new technologies and evidence emerge.
[Collaborate with CDC and FDA]

Statement on Commission Endorsement

The recommendations and action steps of this theme have been endorsed by 23 members of the Commission; 1 member does not endorse Principal Recommendation 1A; 1 member does not endorse the report.

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https://www.nejm.org/doi/full/10.1056/NEJMoa2008457#article_citing_articles

⁷² Van Ness, L. (2020, July 15). *COVID-19 testing falls short in long-term care facilities*. The Pew Charitable Trusts. <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2020/07/15/covid-19-testing-falls-short-in-long-term-care-facilities>

⁷³ Keith, K. (2020, June 25). Feds carve out workplace COVID-19 testing from guaranteed coverage and more. *Health Affairs Blog*. DOI: <https://www.healthaffairs.org/doi/10.1377/hblog20200625.139207/full/>

⁷⁴ Centers for Medicare & Medicaid Services. (2020, March 13). *CMS announces new measures to protect nursing home residents from COVID-19* [Press release]. <https://www.cms.gov/newsroom/press-releases/cms-announces-new-measures-protect-nursing-home-residents-covid-19>

⁷⁵ National Center for Immunization and Respiratory Diseases (NCIRD), Division of Viral Diseases. (2020, February 11). *Testing guidelines for nursing homes*. Centers for Disease Control and Prevention. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html>

⁷⁶ Centers for Medicare & Medicaid Services. (2020, July 22). *Trump administration announces new resources to protect nursing home residents against COVID-19* [Press release]. <https://www.cms.gov/newsroom/press-releases/trump-administration-announces-new-resources-protect-nursing-home-residents-against-covid-19>.

⁷⁷ Coronavirus Commission for Safety and Quality in Nursing Homes (2020, July 7).

⁷⁸ American Health Care Association, National Center Assisted Living. (2020, June 29). *Survey shows processing time of Covid tests for long term care residents and staff a major concern*. American Health Care Association Network. <https://www.ahcancal.org/News-and-Communications/Fact-Sheets/FactSheets/AHCA-NCAL-Survey-Testing-Results.pdf>

⁷⁹ Keith, K. (2020, June 25). Feds carve out workplace COVID-19 testing from guaranteed coverage and more. *Health Affairs Blog*. DOI: <https://www.healthaffairs.org/doi/10.1377/hblog20200625.139207/full/10.1377/hblog20200625.139207>

⁸⁰ Ibid.

⁸¹ Commission member communications with MITRE, Aug. 24, 2020.

⁸² Centers for Medicare & Medicaid Services (2020, March 26). *Clinical Laboratory Improvement Amendments (CLIA) Laboratory Guidance During COVID-19 Public Health Emergency*. Ref: QSO-20-21-CLIA. <https://www.cms.gov/files/document/qso-20-21-clia.pdf-0>.

⁸³ Centers for Medicare & Medicaid Services. (2020, May 18). *Nursing home reopening recommendations for state and local officials*. <http://www.cms.gov/files/document/qso-20-30-nh.pdf>

⁸⁴ MITRE-developed, derived from Commission discussion and/or public input.

⁸⁵ Resident rights, 42 CFR § 483.10(c)(6) (2017).

⁸⁶ Resident rights, 42 CFR §483.10 (e)(6) (2017).

⁸⁷ Resident rights, 42 CFR §483.10 (e)(7) (2017).

3.2 Equipment and PPE

Relates to Objectives



Scale of Public Input



The Commission identified the following primary problems associated with equipment and PPE.

1. Nursing home owners and administrators do not have consistent access to an adequate quantity and quality of PPE,⁸⁸ and traditional nursing home supply chains have been overwhelmed. A recent study found that a fifth of nursing homes had reported a PPE shortage in June and July.⁸⁹
2. Nursing home staff may have gaps in their understanding of best practices for PPE training, use, and reuse, and thus may not be consistently applying best practices.

Response to Date and Emerging Evidence

CMS Actions to Date. In late April, the Federal Emergency Management Agency (FEMA) issued a 14-day supply of PPE to all nursing homes;⁹⁰ at the end of May, CMS and CDC introduced national COVID-19 training modules to provide guidance to healthcare personnel. CMS also issued guidance on April 2 encouraging nursing homes to ensure that all staff were using appropriate PPE when interacting with patients and residents, as well as conserving that equipment when necessary in accordance with CDC guidelines (which have been updated iteratively).⁹¹ Nursing homes report to NHSN on whether they have a seven-day supply of PPE (i.e., N95 masks, surgical masks, eye protection, gowns, gloves, and hand sanitizer),⁹² which enables federal awareness about specific those nursing homes that may be experiencing supply shortfalls. CDC’s data is showing that PPE supply is no longer an issue for 90% of nursing homes, per 7-day reported supply. For example, for the week ending August 16, just 1,354 nursing homes of 14,450 (9.4%) reporting did not have a one-week supply of surgical masks.⁹³

Commission Member Discussions. Commission members are adamant that CMS has the responsibility to work with its federal and SLTT partners to ensure that every nursing home in the country has a continuous and adequate supply of high-quality and properly fitting PPE, and that their staff do not have to provide their own PPE.

“PPE varies a lot in quality. ‘PPE is PPE is PPE,’ just isn’t true!”
-Commission Member

Commission members also underscored as the importance of properly training staff on PPE use.⁹⁴

Public Input. Public comments primarily focused on the need to prioritize PPE supply to nursing home facilities for staff and residents. Many comments also underscored the need for local, statewide, and regional tracking to prepare for a future surge.

Emerging Evidence. See [Appendix C](#) for detailed discussion of the emerging evidence and regulatory background.

Principal Recommendations and Action Steps

The Commission made **three principal recommendations** for procurement, use, and training of adequate and quality PPE in nursing homes.

Principal Recommendation 2A: Assume responsibility for a collaborative process with federal and SLTT partners to ensure nursing home owners and administrators can procure and sustain a three-month supply of high-quality supplies of PPE. This process must provide accountability and oversight.

(*Note:* Some members support this recommendation only if this process provides accountability, funding, and oversight; others support it only if this process provides funding and shared accountability.)

Action Steps

- Develop a process, working with federal partners including CDC, FDA, the Assistant Secretary for Preparedness and Response (ASPR) and FEMA, for procurement of PPE that includes:
 - Coordinated joint purchasing procurement and distribution of PPE with federal and SLTT agencies to ensure adequate availability and quality for nursing homes.
 - Ability to identify status of PPE inventory, procurement pipeline, and projected demand at facility, state, and national levels.
 - Established quality standards and requirements for commercial use of PPE.
 - Ability for CMS to exercise its enforcement authority to ensure compliance and accountability for procurement of recommended supplies of PPE. (*Note:* Some members would amend this recommendation to apply in facilities that can procure and sustain PPE; for facilities that cannot,⁹⁵ CMS will provide support to ensure those facilities can procure and sustain PPE.)
 - Development of standardized, integrated tools to monitor inventory, rotate stockpiles, manage burn rates, and maintain the federally recommended level of supplies.
- Add a requirement in the Emergency Preparedness regulation (42 C.F.R. § 483.73) to include PPE utilization in emergency preparedness and infection control protocols.⁹⁶
- Enhance established federal reporting sites (e.g., NHSN and the Payroll-Based Journal [PBJ]) to capture detailed COVID-19 case reporting, specific staffing information, and status of PPE availability.⁹⁷ (See related [Nursing Home Data recommendations.](#)) [Collaborate with federal partners including the CDC]
- Develop guidelines for nursing home owners and administrators for addressing equipment and PPE shortages (i.e., procurement options when normal supply chains are unavailable or protocols for reallocation of supplies currently stored by states, facilities, and other entities).

Principal Recommendation 2B: Provide specific guidance on the use, decontamination, and reuse of PPE, working with federal partners, including CDC, FDA, and OSHA.

Action Steps

- Develop and provide guidance for when to use different PPE such as face shields, surgical or cloth facemasks, gloves, gowns, and National Institute for Occupational Safety and Health (NIOSH)-approved N95 respirators. This guidance must be specific to nursing home staff residents, contractors, essential care partners, and visitors (including ombudsmen and surveyors). It must also identify expectations during outbreaks, followed by ramping down when appropriate. The guidance should incorporate decision-making based on the level of infection severity within the facility itself and geographic location alike.
- Release guidance for FDA-approved reuse of PPE and other essential equipment, prioritizing the use of N95 masks for high-risk staff. Include a framework for facility medical directors to implement practices most appropriate on a case-by-case basis. (*Note:* some Commission members recommend that CMS promote coordination with state and local authorities to offer fit testing and other training for nursing homes. Other members emphasized the need for a clear process, adequate funding, and an achievable procedure for facilities to meet these standards.) [Collaborate with OSHA]
- Release guidance on fit testing for NIOSH-approved N95 respirators and other tight-fitting respirators (according to available manufacturer specifications).
- Establish requirements and guidance on decontamination of N95 respirators.
- Provide guidelines for equipment and PPE shortages (i.e., refresh/reuse protocols, strategies for extending limited supplies, and use of alternative products where applicable).
- Centralize communications about⁹⁸ and provide training on methods for refresh and reuse of PPE by healthcare personnel in situations when shortages require optimizing and extending the supply and use of PPE. Increase the visibility of CDC Crisis Capacity strategies. [Collaborate with CDC.] (See also [Principal Recommendation 10B](#).)

Principal Recommendation 2C: As needed, collaborate with other federal and state agencies to provide guidance on training to all clinical and nonclinical facility staff on proper use of PPE and equipment, according to available manufacturer specifications. (See also [recommendation on Infection Preventionist](#) under Workforce Ecosystem.)

Action Steps

- Establish national training requirements for infection control and use of PPE for all healthcare personnel, as well as other individuals with direct and indirect contact with residents. This should be incorporated into the training requirements set forth in 42 CFR 483.80 and 42 CFR 483.95.

- Tailor training modules for PPE utilization for administrators, residents, staff, contractors, essential care partners, and visitors.
- Incorporate PPE training modules into the Nursing Home Preventionist Training course and the Infection Prevention and Control Program (IPCP).
- Establish national training standards for staff based on existing core competency standards or other model standards/certifications developed by states.

Statement on Commission Endorsement

The recommendations and action steps of this theme have been endorsed by 24 members of the Commission; 1 member does not endorse the report.

⁸⁸ McGarry, B. E., Grabowski, D. C., & Barnett, M. L. (2020, August 20). Severe Staffing And Personal Protective Equipment Shortages Faced By Nursing Homes During The COVID-19 Pandemic. *Health Affairs (Project Hope)*, 101377hlthaff202001269. Advance online publication.

<https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.01269>

⁸⁹ McGarry, B. E., Grabowski, D. C., & Barnett, M. L. (2020). Severe Staffing And Personal Protective Equipment Shortages Faced By Nursing Homes During The COVID-19 Pandemic. *Health Affairs (Project Hope)*, 101377hlthaff202001269. Advance online publication.

<https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.01269>

⁹⁰ FEMA. (2020, April 30). *Personal protective equipment for Medicare and Medicaid nursing homes* [Press release].

<https://www.fema.gov/news-release/20200727/personal-protective-equipment-medicare-and-medicaid-nursing-homes>

⁹¹ Centers for Medicare and Medicaid Services. (2020, April 2). *COVID-19 long-term care facility guidance*.

<https://www.cms.gov/files/document/4220-covid-19-long-term-care-facility-guidance.pdf>

⁹² Centers for Medicare and Medicaid Services. (2020). *COVID-19 Data Dictionary*.

<https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data-Data-Dictionary/8rzn-j9yt/>

⁹³ Centers for Medicare and Medicaid Services. (2020). *COVID-19 Nursing Home Dataset*.

<https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg/>

⁹⁴ Coronavirus Commission for Safety and Quality in Nursing Homes (2020, July 7).

⁹⁵ MITRE suggests perhaps CMS could assess this by NHSN reporting on 7-day supply.

⁹⁶ MITRE-developed, derived from Commission discussion and/or public input.

⁹⁷ Elizaitis, B. (2020, April 25) *CMS Publishes List of Nursing Home Staffing Levels*. CMS Compliance Group, INC.

<https://cmscompliancegroup.com/2020/04/25/cms-publishes-list-of-nursing-home-staffing-levels/>.

⁹⁸ Centers for Disease Control and Prevention. (2020, July 16). *Optimizing Supply of PPE and Other Equipment during Shortages*. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html>

3.3 Cohorting

Relates to Objectives



Scale of Public Input



The Commission identified two primary problems associated with cohorting.

1. Cohorting is considered a common infection prevention and control technique⁹⁹ and a core response tool against COVID-19.^{100, 101} It has been effective historically, as well as during recent outbreaks of infectious diseases.^{102, 103} Nevertheless, isolation associated with cohorting can instill loneliness and increase the risk for a number of health conditions in residents (e.g., cognitive decline, stroke, high blood pressure, and other complications).¹⁰⁴ Cohorting practices based on COVID-19 status may negatively affect their social and emotional health, contributing to increased anxiety and/or depression among residents.¹⁰⁵
2. Owners and Administrators may not be able to implement existing cohorting guidance because of staffing, equipment, and/or environmental limitations (e.g., cleaning, tight space, lack of physical barriers, inadequate ventilation systems), and may be inappropriately incentivized to isolate residents.^{106, 107}

Response to Date and Emerging Evidence

CMS Actions to Date. CMS issued blanket waivers of certain requirements (e.g., physical environment, transfer, and discharge) to ease cohorting implementation in nursing homes. In conjunction with CDC, it also issued a series of related recommendations.¹⁰⁸ The CDC also issued iterative guidance to help owners and administrators with cohorting-related decisions.¹⁰⁹

Commission Member Discussions. Commission members stressed that, although cohorting is a critical infection prevention and control tool, it has a detrimental effect on residents. They expressed concern that the use of blanket waivers to ease cohorting implementation exacerbates tension between the need to protect residents and staff from COVID-19 and the need to ensure resident rights and quality of life.¹¹⁰

Public Input. The public noted the importance of social and emotional health, along with the need for evidence-based policies regarding cohorting, nursing home design, and visitation. The public noted that significant work remains to be done to balance the costs and benefits of restrictive policies against the consequences of minimal care and decreased socialization.

Emerging Evidence. No additional evidence has been identified at this time.

"Being told you are moving with very little notice and no choice is disturbing but these are unusual circumstances. The mortality rate of nursing home residents in my state is] 31% I think most would choose to cohort quickly if they understood what is at stake. ... Conversations [ahead of time] with the residents about why they need to relocate and resolving their concerns would certainly be the correct way to proceed."

-Commission Member

Principal Recommendations and Action Steps

Principal Recommendation 3A: Update cohorting guidance to balance resident and staff psychological safety and well-being with infection prevention and control.

Action Steps

- Develop clear and concise guidance for cohorting using the Tuberculosis (TB)¹¹¹ Training Module 12B in the CDC’s Infection Preventionist training course¹¹² and the *Recommended Nursing Home Phased Reopening for States*.^{113, 114}

Ensure CMS cohorting guidance:

- Prioritizes resident social and emotional health and minimizes disruption of resident daily routines
- Includes instructions for determining, monitoring, and adapting staffing assignments that maintain cohorts while minimizing inequity of staff workload (see [Principal Recommendation 6B](#) and associated action steps for more details)
- Is adaptable based on community COVID-19 prevalence
- Reflects resident rights to return to original room (within original facility, if they are moved outside the facility) once transmission risk has been mitigated¹¹⁵
- Modify 42 C.F.R. § 483.10 and § 483.15 waivers to:
 - Require nursing homes to proactively communicate via advance written notice (e.g., in email and/or in print) with residents and residents’ representatives specifically about facility cohorting protocols, including protocols specific to the possibility of in-facility and extra-facility transfer.
 - Require that when COVID-19 tests are administered, nursing homes notify residents and residents’ representatives specifically how the facility’s cohorting protocol will be applied upon the receipt of the COVID-19 test results, including whether a positive or negative test will require an in-facility transfer or extra-facility transfer (and, for extra-facility transfers, the options available to the resident).
 - Require that when a test result is received and/or symptoms emerge that require a resident to be isolated and/or transferred in-facility or outside the facility, residents and residents’ representatives are notified about the intent to isolate or transfer and provided additional, case-specific details about that process while maintaining compliance with the Health Insurance Portability and Accountability Act (HIPAA). For transfers outside the facility, require facilities to speak with residents or representatives to choose an alternate facility, unless such conversations would cause a delay presenting a clear danger to residents’ health or safety. Require a minimum of two documented attempts to comply, including method(s), date(s), and time(s).

- Commission a study to identify the effects of cohorting for prolonged periods of indefinite duration, methods for nursing home owners and administrators to address those effects, requirements for implementing isolation, and strategies for adapting practices when a vaccine emerges.¹¹⁶
[Collaborate with the National Academy of Sciences, Engineering, and Medicine (NASEM)]

Principal Recommendation 3B: Update cohorting guidance and reimbursement policy to address differences in nursing home resources (e.g., facility, infrastructure, staff).

Action Steps

- Recommend nursing homes have an observation unit or separate area for new admission or transfer residents. For nursing homes without the ability to create this infrastructure, continue to allow the nursing home to cohort new admissions in another facility for the purpose of observation by waiving requirements in 42 CFR 483.10(c)(5); 483.15(c)(4)(ii), (c)(5)(i) and (iv), (c)(9), and (d); and §483.21(a)(1)(i), (a)(2)(i), and (b)(2)(i). Ensure residents and residents’ representatives receive ongoing communications about observation plans and actions.
- Modify the Resident Assessment Instrument/Minimum Coding Set (RAI/MDS) coding instructions (Chapter, MDS 3.0 RAI Manual O0100M2) to eliminate the possibility of a higher reimbursement rate for residents placed in a room alone (i.e., isolated/quarantined) than that paid for residents who have been cohorting with a group in accordance with CDC and/or CMS COVID-19 cohorting guidelines.
- Redirect and prepare Quality Improvement Network (QIN)-Quality Improvement Organizations (QIO) to assist nursing home providers with development of effective cohorting plans (see [Principal Recommendation 8A](#) and associated action steps for more details).

Statement on Commission Endorsement

The recommendations and action steps of this theme have been endorsed by 23 members of the Commission; 1 member does not endorse Principal Recommendation 3B; 1 member does not endorse the report.

⁹⁹ Lee, T., Jordan, N. N., Sanchez MD, J. L., Gaydos MD, J. C. (2005). Selected nonvaccine interventions to prevent infectious acute respiratory disease. *American Journal of Preventive Medicine*, 28(3), 305-316.
<https://doi.org/10.1016/j.amepre.2004.12.010>

¹⁰⁰ Centers for Disease Control and Prevention. (2020, June 25). *Preparing for COVID-19 in nursing homes*.
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>

¹⁰¹ Sanchez, G. V., Biedron, C., Fink, L. R., Hatfield, K. M., Polistico, J. M. F., Meyer, M. P., Noe, R. S., Copen, C. E., Lyons, A. K., Gonzalez, G., Kiama, K., Lebednick, M., Czander, B. K., Agbonze, A., Surma, A. R., Sandhu, A., Mika,

V. H., Prentiss, T., Zervos, J., ... (2020, July 10). *Initial and repeated point prevalence surveys to inform SARS-CoV-2 infection prevention in 26 skilled nursing facilities – Detroit, Michigan, March-May 2020*. Centers for Disease Control and Prevention. https://www.cdc.gov/mmwr/volumes/69/wr/mm6927e1.htm?s_cid=mm6927e1_w

¹⁰² Such as “MRSA, VRE, ESBL-producing *K. pneumoniae*, *S. marcescens*, *Acinetobacter baumannii*, and *P. aeruginosa*.” Rosenberger, L. H., Riccio, L. M., Campbell, K. T., Politano, A. D., & Sawyer, R. G. (2012). Quarantine, isolation, and cohorting: From Cholera to Klebsiella. *Surgical Infections*, 3(2), 69–73. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4845677/>

¹⁰³ Cohorting is the process of locating individuals with the same condition in the same space with the intent of reducing or eliminating interaction between infected persons with uninfected persons.

¹⁰⁴ Simard, J., & Ladislav V. (2020, May 2). Loneliness and isolation in long-term care and the COVID-19 pandemic. *Journal of the American Medical Directors Association*, 21(7), 966-967. <https://doi.org/10.1016/j.jamda.2020.05.006>

¹⁰⁵ Simard, J., & Ladislav V. (2020, May 2). Loneliness and isolation in long-term care and the COVID-19 pandemic. *Journal of the American Medical Directors Association*, 21(7), 966-967. <https://doi.org/10.1016/j.jamda.2020.05.006>

¹⁰⁶ Iaboni, A., Cockburn, A., Marcil, M., Rodrigues, K., Marshall, C., Garcia, M. A., Quirt, H., Reynolds, K. B., Keren, R., & Flint, A. J. (2020). Achieving safe, effective, and compassionate quarantine or isolation of older adults with dementia in nursing homes. *The American Journal of Geriatric Psychiatry: Official Journal of the American Association for Geriatric Psychiatry*, 28(8), 835–838. <https://doi.org/10.1016/j.jagp.2020.04.025>

¹⁰⁷ Cohen, C. C., Pogorzelska-Maziarz, M., Herzig, C. T., Carter, E. J., Bjarnadottir, R., Semeraro, P., Travers, J. L., & Stone, P. W. (2015). Infection prevention and control in nursing homes: A qualitative study of decision-making regarding isolation-based practices. *BMJ Quality & Safety*, 24(10), 630–636. <https://doi.org/10.1136/bmjqs-2015-003952>

¹⁰⁸ Centers for Medicare & Medicaid Services. (2020, April 13). *2019 Novel Coronavirus (COVID-19) long term care facility transfer scenarios*. <https://www.cms.gov/files/document/qso-20-25-nh.pdf>; Centers for Medicare and Medicaid Services. (2020, July 9). *Long term care facilities (skilled nursing facilities and/or nursing facilities): CMS flexibilities to fight COVID-19*. <https://www.cms.gov/files/document/covid-long-term-care-facilities.pdf>; Centers for Disease Control and Prevention. (2020, June 25). *Preparing for COVID-19 in nursing homes*. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>; Centers for Medicare and Medicaid Services. (2020, April 2). *COVID-19 long-term care facility guidance*. <https://www.cms.gov/files/document/4220-covid-19-long-term-care-facility-guidance.pdf>

¹⁰⁹ Centers for Disease Control and Prevention. (2020, April 30). *Responding to Coronavirus (COVID-19) in nursing homes*. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html>

¹¹⁰ Coronavirus Commission for Safety and Quality in Nursing Homes (2020, July 7).

¹¹¹ Tuberculosis in general, and the TB training specifically, is considered analogous to COVID because both are respiratory infections that are spread by a person who releases droplets into the air when breathing out. Secondly, the presence of comorbidities can result in poor outcomes for both diseases. In addition, CDC provided respiratory infection control measures for both COVID-19 and TB, including the following:

- Triage, early identification, and separation of symptomatic patients
- Fast tracking or expedited service
- Implementation of droplet and contact precautions
- Frequent handwashing
- Implement environmental engineering controls, for example, physical barriers and dedicated pathways to guide symptomatic patients through triage areas, remote or outdoor triage stations for patients with respiratory symptoms
- Use of personal protective equipment (PPE)

Centers for Disease Control and Prevention. (2020, August 17). *Operational considerations for maintaining essential services and providing prevention, care, and treatment for Tuberculosis (TB) in low-resource non-US settings during the COVID-19 pandemic*. <https://www.cdc.gov/coronavirus/2019-ncov/global-covid-19/TB-non-us-settings.html>

¹¹² Centers for Disease Control and Prevention. (n.d.). *Nursing home infection preventionist training course*. <http://www.train.org/cdctrain/course/1081820/>

¹¹³ Centers for Medicare and Medicaid Services. (2020, May 18). *Nursing home reopening recommendations for state and local officials*. <http://www.cms.gov/files/document/qso-20-30-nh.pdf>

¹¹⁴ MITRE-developed, derived from Commission discussion and/or public input.

¹¹⁵ MITRE-developed, derived from Commission discussion and/or public input.

¹¹⁶ MITRE-developed, derived from Commission discussion and/or public input.

3.4 Visitation



The Commission identified four primary problems associated with visitation.

1. Although visitation restrictions have partially protected the physical health of residents, the practice also has resulted in unintended harm. Residents experience loneliness, anxiety, and depression due to prolonged separation from families and loved ones.^{117, 118} These measures also compromise the ability of families and guardians to validate resident well-being and safety, and caused significant distress for families.¹¹⁹
2. Virtual visitation often provides an insufficient substitute to address resident needs. The gap between in-person and virtual visitation is even more acute when combined with limitations due to differing physical and cognitive abilities; resident, family, and/or staff unfamiliarity with proper equipment use and functionality; and equipment and internet availability.¹²⁰
3. The extent of this unintended harm has not been adequately assessed; nursing home staff also have under-prioritized the continuation of routine daily activities to address infectious disease protocols, thus exacerbating the unintended harm caused by overly restrictive visitation policies.¹²¹
4. Visitation guidance is currently unclear. CMS and its federal partners have issued directives and guidance pertaining to visitation during the pandemic in multiple documents, making it challenging for nursing homes to meet (and CMS to enforce) federal expectations or leverage evolving flexibility.

Response to Date and Emerging Evidence

CMS Actions to Date. After initially advising nursing home owners and administrators to adopt restrictive visitation policies, CMS subsequently clarified its guidance, expanded visitation guidelines in compassionate care and other situations, and provided suggestions to help residents connect with their families.¹²²

Commission Member Discussions. Throughout their convenings,¹²³ many members expressed serious concerns about the effect restrictions have on residents’ mental health and well-being; they supported finding ways to increase visitation without compromising infection prevention and control. Other members questioned whether relaxing restrictions—especially in areas with high community prevalence—would increase the risk of COVID-19 transmission. Commission members also discussed the need to monitor for and prevent the misuse of antipsychotic and antidepressant medication, especially among isolated residents.

Public Input. Public commenters overwhelmingly supported policies grounded in person-centered care practices, viewed improving visitation as vital to support nursing home residents, and expressed the importance of maintaining communication with family and essential care partners. These issues received the greatest volume of public input.

Emerging Evidence: The most effective way to prevent spreading of SARS-CoV-2 at the population level is to limit the frequency and duration of contact between an infected individual and an uninfected individual.¹²⁴ SARS-CoV-2’s incubation period (estimated by CDC to extend up to 14 days),¹²⁵ coupled with emerging evidence of spreading by asymptomatic carriers of the virus, means that visitors without observable symptoms can infect nursing home residents and staff. Physical separation of visitors and residents is an effective way to reduce spread of the virus;¹²⁶ nevertheless, residents rely on visits with loved ones and caregivers outside of the nursing home (e.g., family members, friends) for care and critical emotional support, and those visitors in turn rely on visitation to ensure resident safety and quality of care.^{127, 128, 129} Maintaining those relationships in the absence of in-person visitation has posed a challenge due to limited supply of technology,¹³⁰ lack of staff training on that technology, and difficulty tracking evolving CMS expectations.

“The decision has been made for Mom and thousands of her peers to choose longevity over quality of life. This includes many folks on hospice...they are simply robbed of their quality. For people with dementia like my mother, today is their best day. Tomorrow will be a little worse and who knows if there will be a six-months from now... We are losing precious time.”

-Public Input

Principal Recommendations and Action Steps

Principal Recommendation 4A: Emphasize that visitation is a vital resident right. Update and release consolidated, evidence-based guidance on safely increasing controlled, in-person visitation prior to federal Phase 3¹³¹ reopening.

Action Steps

- Provide updated guidance on in-person visitation that immediately enables nursing home owners and administrators to adjust protocols and safely increase in-person visitation by essential care partners, compassionate care visitors, and ombudsmen based on emerging and established evidence. This CMS in-person visitation guidance should:
 - Restate the existing right to visitation and clarify modifications to this right for each phase of the pandemic.
 - Describe or restate minimum standards for visitor testing, training on and use of facial coverings and other PPE, temperature checks, physical distancing, visitor movement restrictions (e.g., separate visitor rooms, indoor/outdoor options, staggered visitation schedules), post-visit disinfection, instructional signage, supervision and assistance from staff, and SARS-CoV-2 positive visits.
 - Outline how to adapt visitation policies based on local prevalence of COVID-19 cases internal and external to nursing homes.
 - Require nursing home owners and administrators to encourage residents to designate an Essential Care Partner that can visit in person when other visitors may not be

- allowed; when a resident is unable to do so, the legal surrogate could serve as an Essential Care Partner or appoint an alternate, such as a loved one.
- Include a person-centered, consumer-driven definition of compassionate care situations (e.g., not limited to hospice care or last days or hours of life), along with criteria for assessing when compassionate care and extended end-of-life visitation by at least one visitor is appropriate.
- Stress that ombudsmen may visit residents, and relay information to families and guardians, prior to federal Phase 3¹³² reopening when they are able to observe infection prevention and control standards.

Principal Recommendation 4B: Update and release consolidated, evidence-based guidance on effectively planning for and implementing virtual visitation tools and techniques.

Action Steps

- Provide guidance on virtual visitation that specifies evidence-based protocols for acquiring, using, and safely sharing technology and communicative devices (e.g., cell phones, tablets, webcams, other web applications/platforms) to safely facilitate virtual visitation. This CMS virtual visitation guidance should:
 - Encourage safe sharing of sanitized technology that is readily accessible (e.g., large button phones) and available to residents (e.g., at the closest nursing station).
 - Provide learning resources about various technology tools that nursing home staff can use to communicate with residents, families, and staff (see [Principal Recommendation 8A](#) and associated action steps for more details).
 - Include information on accessing and using low-cost, creative methods for maintaining contact between residents and their loved ones (e.g., messages through windows, Jitterbug flip phone, postcards).^{133, 134}
- Continue to facilitate the sharing of ideas about virtual visitation options among nursing home owners and administrators.
- Encourage state agencies to approve applications for the use of civil money penalty (CMP) funds for the purpose of providing communicative devices for virtual visitation.¹³⁵

Principal Recommendation 4C: Provide resources to help nursing home staff assess and improve the mental health and psychosocial well-being of residents during and after the pandemic.

Action Steps

- Develop and distribute a mental health supplemental assessment to help nursing home staff assess and improve the psychosocial well-being of residents exhibiting a mental health status change. The supplemental assessment should:
 - Contain assessment items separate from the current RAI/MDS questions on mood and behavior that would identify when a resident is suffering emotionally due to isolation and lack of family contact
 - Include adaptation options so nursing home staff can tailor items to enhance their current resident assessments and meet unique needs of residents¹³⁶
 - Outline instruction for implementation by staff with training in behavioral health¹³⁷
 - Inform resident care, recognizing that residents continue to have the right to shape their own care plans
- Monitor a subset of data generated from mental health supplemental assessment use and resultant care changes to assess impact; consider formally integrating this supplemental assessment into the RAI required at 42 C.F.R. § 483.20 in place of outdated or less-comprehensive mental health assessment components.
- Issue guidance that promotes regular socialization within facilities and outside of resident rooms; prohibits unnecessary isolation within resident rooms; reinforces the prohibition of the misuse of antipsychotic and antidepressant medications; and emphasizes the importance of routine daily activities (e.g., showering and personal hygiene, communal meals, meditation, exercise).
- Distribute guidance for accessing and integrating telehealth-based mental health services for nursing home residents.¹³⁸
- Provide training at no cost to direct-care providers about psychological first aid and trauma-informed care. See also [Principal Recommendation 8A](#) and associated action steps for more details.
[Collaborate with CDC and/or FEMA]
- Amend 42 CFR § 483.10 to include differentiated reference to compassionate care and hospice care under the residents' rights provision; define contingencies for emergencies.

Principal Recommendation 4D: Assess, streamline, and increase the accessibility of COVID-19-related directives, guidance, and resources on visitation into a single source.

Action Steps

- Identify all of CMS's COVID-19 ideas, suggestions, guidance, frequently asked questions (FAQ), and directives to date regarding visitation ("visitation information").¹³⁹
- Analyze CMS visitation information released to date for accuracy and actionability.¹⁴⁰

- Synthesize visitation information into a single, user-friendly source accessible to all stakeholder groups.
- Add a single, user-friendly visitation information source to dynamic multi-user interface enabling nursing home staff to exchange updated information with CMS and its federal partners, as well as make evidence-based decisions about visitation policies and procedures (see [Data Principal Recommendation 10B](#) and associated action steps for more details).
- Establish an operating procedure to ensure timely updates on visitation based on emerging evidence.¹⁴¹
- Update regularly new single visitation source based on emerging evidence.
- Harmonize federal, state, and local visitation guidance, ideally through single, user-friendly, dynamic multi-user interface (see [Data Principal Recommendation 10B](#) and associated action steps for more details).
[Collaborate with federal partners; SLTT]

Statement on Commission Endorsement

The recommendations and action steps of this theme have been endorsed by 23 members of the Commission; 1 member does not endorse Principal Recommendation 4A; 1 member does not endorse the report.

¹¹⁷ Abbasi, J. (2020, July 16). Social Isolation—the Other COVID-19 Threat in Nursing Homes. *JAMA* 324(7):619-620. doi:10.1001/jama.2020.13484 <https://jamanetwork.com/journals/jama/article-abstract/2768640>

¹¹⁸ Chidambaram, P. (2020, March 13). *Data Note: How might Coronavirus Affect Residents in Nursing Facilities?* Kaiser Family Foundation. <https://www.kff.org/coronavirus-covid-19/issue-brief/data-note-how-might-coronavirus-affect-residents-in-nursing-facilities/>

¹¹⁹ Hado, E., & Feinberg, L.F. (2020, May 22). Amid the COVID-19 pandemic, meaningful communication between family caregivers and residents of long-term care facilities is imperative. *Journal of Aging and Social Policy*, 32(4-5), 410-415. <https://doi.org/10.1080/08959420.2020.1765684>; Grabowski, D. C., & Mitchell, S. L. (2009). Family oversight and the quality of nursing home care for residents with advanced dementia. *Medical Care*, 47(5), 568-574. <https://dx.doi.org/10.1097%2FMLR.0b013e318195fce7>; Simard, J., Volicer, L. (2020). Loneliness and isolation in long-term care and the covid-19 pandemic. *The Journal of Post-Acute and Long-Term Care Medicine*, 21(7), 966-967. <https://doi.org/10.1016/j.jamda.2020.05.006>

¹²⁰ Soregel, A. (2020, June 11). *Nursing homes receive tech devices thanks to government-nonprofit funding*. AARP. <https://www.aarp.org/caregiving/health/info-2020/more-nursing-home-virtual-visits.html>

¹²¹ Simard, J., & Volicer, L. (2020). Loneliness and isolation in long-term care and the Covid-19 pandemic. *The Journal of Post-Acute and Long-Term Care Medicine*, 21(7), 966-967. [https://www.jamda.com/article/S1525-8610\(20\)30373-X/fulltext](https://www.jamda.com/article/S1525-8610(20)30373-X/fulltext)

¹²² Center for Clinical Standards and Quality. (2020, March 13). *Guidance for infection control and prevention of Coronavirus disease 2019 (COVID-19) in nursing homes (revised)*. Centers for Medicare and Medicaid Services. <https://www.cms.gov/files/document/3-13-2020-nursing-home-guidance-covid-19.pdf>; Centers for Medicare and Medicaid Services. (2020, June 23). *Frequently asked questions on nursing home visitation*. <https://www.cms.gov/files/document/covid-visitation-nursing-home-residents.pdf>; Center for Clinical Standards and Quality. (2020, April 24). *Nursing home five star quality rating system updates, nursing home staff counts, and frequently asked questions*. Centers for Medicare and Medicaid Services. <https://www.cms.gov/files/document/qso-20-28-nh.pdf>; Center for Clinical Standards and Quality. (2020, May 6). *Interim final rule updating requirements for*

notification of confirmed and suspected COVID-19 cases among residents of staff in nursing homes. Centers for Medicare and Medicaid Services. <https://www.cms.gov/files/document/qso-20-29-nh.pdf>

¹²³ Coronavirus Commission for Safety and Quality in Nursing Homes (2020, July 7).

¹²⁴ Qualls, N., Levitt, A., Kanade, N., Wright-Jegade, N., Dopson, S., & Biggerstaff, M. (2017). Community mitigation guidelines to prevent pandemic influenza - United States, 2017. *MMWR. Recommendations and reports: Morbidity and mortality weekly report. Recommendations and reports*, 66(1), 1-34. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5837128/>

¹²⁵ Centers for Disease Control and Prevention. (2020, June 30). *Interim clinical guidance for management of patients with confirmed coronavirus disease (COVID-19)*. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html>

¹²⁶ Arons, M. M., Hatfield, K. M., Reddy, S. C., Kimball, A., et al. (2020). Presymptomatic SARS-CoV-2 infections and transmission in a skilled nursing facility. *New England Journal of Medicine*, 382, 2081-2090. https://www.nejm.org/doi/full/10.1056/NEJMoa2008457#article_citing_articles

¹²⁷ Frampton, S., Agrawal, S., Guastello, S. (2020, July 6). Guidelines for Family Presence Policies During the COVID-19 Pandemic. *JAMA*. <https://jamanetwork.com/channels/health-forum/fullarticle/2768108>

¹²⁸ Hado E. & Feinberg L. F. (2020, April 30). Amid the COVID-19 pandemic, meaningful communication between family caregivers and residents of long-term care facilities is imperative. *Families and Caregivers of Older Adults*, 32(4-5), 410-415. doi: <https://doi.org/10.1080/08959420.2020.1765684>

¹²⁹ Grabowski, D. C., Mitchell, S. L. (2009). Family oversight and the quality of nursing home care for residents with advanced dementia. *Medical Care*, 47(5), 568-574. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2709799/>

¹³⁰ Soergel A. (2020, June 11). *Nursing homes receive tech devices thanks to government-nonprofit funding*. AARP. <https://www.aarp.org/caregiving/health/info-2020/more-nursing-home-virtual-visits.html>

¹³¹ Centers for Disease Control and Prevention (2020). *CDC Activities and Initiatives Supporting the COVID-19 Response and the President's Plan for Opening America Up Again*. <https://www.cdc.gov/coronavirus/2019-ncov/downloads/php/CDC-Activities-Initiatives-for-COVID-19-Response.pdf>

¹³² Centers for Disease Control and Prevention (2020). *CDC Activities and Initiatives Supporting the COVID-19 Response and the President's Plan for Opening America Up Again*. <https://www.cdc.gov/coronavirus/2019-ncov/downloads/php/CDC-Activities-Initiatives-for-COVID-19-Response.pdf>

¹³³ Simard, J., Volicer, L. (2020). Loneliness and isolation in long-term care and the Covid-19 pandemic. *The Journal of Post-Acute and Long-Term Care Medicine*, 21(7), 966-967. <https://doi.org/10.1016/j.jamda.2020.05.006>

¹³⁴ MITRE-developed, derived from Commission discussion and/or public input.

¹³⁵ MITRE-developed, derived from Commission discussion and/or public input.

¹³⁶ MITRE-developed, derived from Commission discussion and/or public input.

¹³⁷ MITRE-developed, derived from Commission discussion and/or public input.

¹³⁸ Verma, S. (2020, July 15). *Early impact of CMS expansion of Medicare telehealth during COVID-19*. Health Affairs. <https://www.healthaffairs.org/doi/10.1377/hblog20200715.454789/full/>

¹³⁹ MITRE-developed, derived from Commission discussion and/or public input.

¹⁴⁰ MITRE-developed, derived from Commission discussion and/or public input.

¹⁴¹ MITRE-developed, derived from Commission discussion and/or public input.

3.5 Communication



The Commission identified the following primary problem associated with communication.

1. Knowledge about COVID-19—including incidence, prevalence, virulence, symptoms, prevention, control, treatment, and recovery—is rapidly evolving. Nursing homes are challenged in keeping nursing home residents and their loved ones informed about the most up-to-date information on COVID-19, related protocols, and policies.

Response to Date and Emerging Evidence

CMS Actions to Date: CMS updated regulations¹⁴² and provided guidelines¹⁴³ to nursing home owners and administrators regarding communications with residents and caregivers during the COVID-19 pandemic. These measures generally recommend nursing home staff maintain a person-centered approach to communications and to seek alternatives for communication (e.g., emails, letters, and signage). CMS also provided examples of nursing home communication from various states.¹⁴⁴ The guidance and follow-up examples do not address existing regulatory compliance framework for providing notice where it is required, and do not establish nationwide minimum standards for level and type of communication.

Commission Member Discussions: Throughout their convenings,¹⁴⁵ several Commission members shared approaches to communication with residents, essential care partners, and families.¹⁴⁶ Commission members noted ambiguity in CMS’s guidance, citing the need for more detail related to message type, recipients, and accessibility. Additionally, members expressed concerns about issues involving affordability of technology, privacy, meeting family member expectations, and inconsistencies in staff availability to manage communications.

Public Input: Public comments expressed interest in keeping essential care partners, resident representatives, family members, and loved ones informed about resident well-being and nursing home policies and practices in a unified, accessible, consistent, and transparent manner.

Emerging Evidence: Over the course of the pandemic, communications strategies have varied widely across states and facilities. Additionally, the pace of information flow during the pandemic has sparked leading long-term care stakeholders to encourage nursing home owners and administrators to hasten their communication processes: “Because information about the outbreak is evolving rapidly, often on a daily basis, facilities should be prepared to update their messaging quickly to ensure [residents] and family members have the most current information they need to stay safe and healthy.”¹⁴⁷

“[Facilities are obligated]... to notify residents, family members of infections or likely infections within the facility. But the sense...[is] there's still too much ambiguity there, that there needs to be more detail to make sure that that information is presented in a way that's understandable.”

-Commission Member

See [Appendix C](#) for additional detailed discussion of the emerging evidence and regulatory background.

Principal Recommendation and Action Steps

Principal Recommendation 5A: Increase specificity and expand breadth of guidance on communications between nursing home staff, residents, and families.

Action Steps

- Provide standardized templates for email blasts, newsletters, bulletins, town hall discussion guides, and the like to be used when issuing regular updates. Allow nursing home staff to tailor their communication to the literacy and cultural needs of recipients (including residents, essential care partners, resident representatives, family members, loved ones, and advocates).
- Define the type of information that nursing home staff are expected to communicate (e.g., specifics about a cohorting plan; transfer and discharge rights during phases of an emergency; visitation and/or connection options; options for residents to share feedback; screening/testing protocols and policies; COVID-19 cases and deaths).
- Define time-sensitivity of key messages (e.g., about transfers, discharge, hospitalization).¹⁴⁸
- Require an individualized communication plan as part of each nursing home resident's individual care plan, documenting preferred mode (e.g., recordings, letters, phone, video, in-person) and frequency of communications; with whom to engage (e.g., residents, providers, loved ones; one-on-one, small groups, or large groups); and action steps for missed communications.
- Assess and advise nursing home owners and administrators on how federal COVID-19 relief funds can support adoption of multimedia communication systems (e.g., text, phone, email, virtual townhalls, websites, applications, cameras).
- Amend federal requirements for nursing homes to create and implement protocols for the adoption of multimedia communication systems.¹⁴⁹
- Consider long-term regulations requiring nursing home owners and administrators to integrate these specific details in communications.

Statement on Commission Endorsement

The recommendations and action steps of this theme have been endorsed by 24 members of the Commission; 1 member does not endorse the report.

¹⁴² The requirement was established at 42 C.F.R. § 483.80(g)(3) as published at 85 Fed. Reg. 27550 (May 8, 2020).

¹⁴³ Centers for Medicare & Medicaid Services Center for Clinical Standards and Quality/Quality, Safety & Oversight Group. (2020, March 13). *Memorandum to state survey agency directors: guidance for infection control and*

prevention of coronavirus disease 2019 (COVID-19) in nursing homes (REVISED). Centers for Medicare & Medicaid Services. <https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf>.

¹⁴⁴ Center for Medicare & Medicaid Services. (2020). *Toolkit on state actions to mitigate COVID-19 prevalence in nursing homes*. <https://www.cms.gov/files/document/covid-toolkit-states-mitigate-covid-19-nursing-homes.pdf>.

¹⁴⁵ Coronavirus Commission for Safety and Quality in Nursing Homes (2020, July 7).

¹⁴⁶ Commission members cited communications methods like having 24-hour communication hotlines, granting every press interview to convey information to the public, and hosting up to 20,000 video chats in one facility.

¹⁴⁷ Feldman, V. (2020, March 31). *Communicating with patients and families during COVID-19: Five messages to consider*. McKnight's Long-Term Care News. <https://www.mcknights.com/marketplace/communicating-with-patients-and-families-during-covid-19-five-messages-to-consider/>.

¹⁴⁸ MITRE-developed, derived from Commission discussion and/or public input.

¹⁴⁹ MITRE-developed, derived from Commission discussion and/or public input.

**3.6 Workforce Ecosystem:
Stopgaps for Resident Safety**



The Commission identified five primary problems associated with workforce ecosystem stopgaps for resident safety.

1. The pandemic has exacerbated long-standing workforce ecosystem (education, certification/licensure, recruitment, training, retention) challenges.^{150, 151} Low wages, high resident-to-staff ratios,¹⁵² increased pressure to deliver care for residents with complex needs under difficult conditions, and a dearth of systemic support significantly contribute to current gaps in care for nursing home residents.¹⁵³
2. Direct-providers who work across multiple facilities face an increased risk of SARS-CoV-2 infection; nonetheless, systemic workforce ecosystem problems essentially necessitate working for multiple employers. A preliminary analysis from CDC concluded that these professionals—along with direct-care providers continuing to work while sick—helped hasten the spread of SARS-CoV-2.¹⁵⁴
3. SARS-CoV-2 infection can cause sudden clinical changes that require astute triage, assessment, intervention, and stabilization and/or transfer of the resident to a higher level of care. These capabilities fall within the scope of practice of a Registered Nurse (RN),¹⁵⁵ but they are insufficiently present in nursing homes,^{156, 157} especially during overnight and weekend hours. As a result, Licensed Practical Nurses (LPNs)¹⁵⁸ and Certified Nursing Assistants (CNAs) are called upon to complete tasks that may fall beyond their scope of practice.
4. Current regulations require nursing home owners and administrators to designate a part-time, minimally qualified infection preventionist.¹⁵⁹ This position is traditionally assigned to a supervisor, nursing manager, or provider as an added (rather than a core) responsibility, yielding insufficient response to the demands of the current pandemic.¹⁶⁰
5. Workforce educators with expertise in infection prevention and control are insufficiently used in nursing homes. When employed, nursing home owners and administrators often contract part-time infection preventionists without educator training and lacking insight into local nursing home context. This underutilization and insufficient integration of infection prevention education professionals (IP Educators) has yielded knowledge and skills deficits among the nursing home workforce—deficiencies that have been compounded by the pandemic.¹⁶¹ Maintaining updated standards of care requires dedicated, on-site IP Educators.¹⁶²

Response to Date and Emerging Evidence

CMS Actions to Date. CMS’s distribution of \$5 billion for nursing homes from the Provider Relief Fund authorized by the CARES Act¹⁶³ is a potential funding source to hire additional staff and support existing staff. CMS also issued several informational bulletins to help nursing home

owners and administrators address resident safety concerns stemming from inadequate infection prevention and control practices.^{164, 165, 166, 167} CMS deployed “strike teams” to assess nursing homes on infection prevention and control;¹⁶⁸ in practice, however, these strike teams have focused on verifying competency, rather than providing instruction.¹⁶⁹

Commission Member Discussions. Commission members emphasized at every convening¹⁷⁰ that CMS must do more to address emergency staffing shortages, including providing hazard pay. Commission members also highlighted the need for more robust on-site infection prevention and control oversight, training, and interventions, but added that nursing home owners and administrators require additional support to implement such measures.

Public Input. Comments frequently mentioned ensuring the ability to maintain critical staffing levels during emergencies. Submitted materials included scholarly articles reviewing studies from multiple geographic areas that tied resident outcomes and infection rates to the staffing levels of various facilities. The public also noted the need for enhanced workforce training—especially in infection prevention and control—to ensure a constant state of readiness to respond to outbreaks.

“The direct care staff need targeted training, adequate equipment and supplies, stress and grief support, and access to paid leave and other benefits. Addressing these needs is necessary to ensure this workforce can provide continuous, quality care for nursing home residents in emergencies and in general.”

-Public Input

Emerging Evidence. The CDC underscored that maintaining appropriate staffing levels is essential to providing a safe working environment and proper care; it developed guidelines for healthcare facilities to address potential staffing shortfalls during the pandemic.^{171, 172}

See [Appendix C](#) for additional detailed discussion of the emerging evidence and regulatory background.

Principal Recommendations and Action Steps

The Commission made five principal recommendations related to workforce stopgaps for resident safety.

Principal Recommendation 6A: Mobilize resources to support a fatigued nursing home workforce and assess minimum care standards.

Action Steps

- Assess federal relief funds for hazard pay options; advise nursing home owners and administrators how to access and distribute hazard pay.

- Urge nursing home owners and administrators to incorporate increased break/recuperation time, as well as time for proper PPE donning and doffing for direct-care providers as part of emergency-management planning to minimize the physiological stress of prolonged use of PPE (see [Principal Recommendation 8A](#) and associated action steps for more details).¹⁷³
- Reinforce the importance of medical director engagement in nursing home emergency management planning and execution.
- Assess and adapt existing COVID-19 data collection and analysis to anticipate hotspots, along with workforce surge needs (see [Principal Recommendation 10A](#) and associated action steps for more details).
- Update existing emergency management plans to reflect emerging workforce shortages and surge-support resources.
[Collaborate with FEMA and State Departments of Health]
- Update interstate compact language addressing public health emergencies to include licensed and certified individuals (e.g., CNAs) to support a surge-staffing pool in hotspots.
[Collaborate with state governments]
- Issue guidance based on recent research¹⁷⁴ that defines updated, acuity-adjusted, evidence-based, person-centered minimum care standards. These standards should specify hours of care per resident per day during normal and emergency operations alike, and require nursing homes to adhere to these standards.

Principal Recommendation 6B: Provide equity-oriented guidance that allows nursing home workforce members to safely continue to work in multiple nursing homes while adhering to infection prevention and control practices.

Action Steps

- Develop and distribute guidance for direct care staffing assignment patterns that require direct care providers to work only with residents testing negative for SARS-CoV-2 or only with residents testing positive for SARS-CoV-2 across nursing homes within a given week.¹⁷⁵ This guidance should include the following specifications:
 - Diagnostically test direct-care providers before rotating them from caring for residents with SARS-CoV-2 infection to caring for residents without SARS-CoV-2 infection.
 - Direct-care providers should work at no more than two nursing homes during the pandemic to allow for accurate contact tracing and monitoring.
- Identify federal relief funds to provide paid quarantine-leave options to direct-care providers testing positive for SARS-CoV-2. Advise nursing homes how to access and distribute paid leave to those providers during their quarantine.

- Catalyze adoption of evidence-based, equitable, infection prevention and control-oriented assignment patterns by nursing home administrators and direct-care providers.¹⁷⁶
[Collaborate with national professional associations and organizations representing nursing homes and/or their staff]
- Develop regulations requiring integration of multi-employer staffing assignment patterns for into emergency planning.
- Support increased wages for nursing home staff through Medicaid and Medicare payment reform to disincentivize working for multiple employers.

Principal Recommendation 6C: Support 24/7 RN staffing resources at nursing homes in the event of a positive SARS-CoV-2 test within that facility.

Action Steps

- Leverage federal relief funds, and coordinate the use of regional health system resources, to provide 24/7 RN staff augmentation in nursing homes with SARS-CoV-2 incidence among residents.
[Collaborate with state and local authorities]
- Monitor and evaluate mortality and transfer rates of residents who have tested positive for SARS-CoV-2 when an RN has been consistently present during their care.
- Commission a study to establish an evidence-based standard for specific, competency-based care requirements during times of normal and emergency operations alike.

Principal Recommendation 6D: Identify and immediately leverage certified infection preventionists to support nursing homes' infection prevention needs.

Action Steps

- Identify and deploy infection-preventionist resources to provide immediate assistance to nursing homes without full-time infection prevention support, prioritizing those nursing homes in current or anticipated hotspots.
[Collaborate with FEMA, the National Guard, the Public Health Service Corps (USPHC), infection prevention recruiting companies, and infection prevention professional organizations (e.g., Association for Professionals in Infection Control (APIC) and/or Society for Healthcare Epidemiology of America (SHEA))]

Principal Recommendation 6E: Require nursing homes to employ infection preventionist(s) with educator capabilities.

Action Steps

- Require infection preventionists to have educator capabilities (IP Educators). Require these IP Educators to provide and document competency-driven, experiential training on core practice; crisis standards of care, including fit testing of N95 masks and PPE

donning and doffing; and crisis recovery. Also require regular assessments and competency achievement of all direct and contract staff (e.g., administrators, nurses, CNAs, environmental services, maintenance, food service, ancillary staff). Encourage IP Educators to include residents in this training and counsel.

- Provide templates for IP Educators to track infection prevention and control onboarding introduction, continuous training, and competency achievement for all staff.
- Develop and distribute to IP Educators competency and self-efficacy measurements for proper PPE use and reuse.
[Collaborate with CDC]
- Endorse individual infection prevention and control competency assessment and achievement by all nursing home staff at an 80% threshold or higher.
- Encourage the provision of collaborative technical assistance from infection control and prevention experts for on-site IP Educators, including support for N95 mask fit testing (see [Recommendation 8A](#) and associated actions steps for more details).
[[Collaborate with state health departments and QIOs]
- Develop partnerships with acute-care and academic facilities to share simulation resources with nursing homes.
[Collaborate with state and local authorities]
- Encourage state agencies to approve nursing home owners' and administrators' applications to use CMP funds for infection prevention and control training costs.^{177, 178}
- Include audits of IP education provision and participation, and related IP emergency management protocols, in QAPI programs.¹⁷⁹
- Establish an evidence-based standard for an IP Educator full-time equivalent (FTE) to bed ratio, including considerations for Health Professional Shortage Areas (HPSA).

Statement on Commission Endorsement

The recommendations and action steps of this theme have been endorsed by 14 members of the Commission; 5 members do not endorse Principal Recommendation 6A; 4 members do not endorse Principal Recommendation 6C; 2 members do not endorse Principal Recommendation 6D; 4 members do not endorse Principal Recommendation 6E; 1 member does not endorse the report.

¹⁵⁰ United States Senate Commission on Long Term Care. (2013). *Commission on long-term care: Report to the Congress*. <https://catalog.archives.gov/id/7741376>; Quality Improvement Organizations. (2019, June). *Resources to support staff stability in post-acute and long-term care settings*. https://qioprogram.org/sites/default/files/editors/141/Resources_To_Support_Staff_Stability_20190626_508.pdf;

- Wofford, P. (2019, July 11). *Nurses say staffing ratios in long term care facilities are unsafe*. Nurse.org. <https://nurse.org/articles/nurse-staffing-unsafe-long-care-facilities/>
- ¹⁵¹ Grabowski, D. & Mor, V. (2020). Nursing home care in crisis in the wake of COVID-19. *JAMA*. 324(1), 23–24. doi:10.1001/jama.2020.8524
- ¹⁵² Wofford, P. (2019, July 11). *Nurses say staffing ratios in long term care facilities are unsafe*. Nurse.org. <https://nurse.org/articles/nurse-staffing-unsafe-long-care-facilities/>
- ¹⁵³ Coronavirus Commission for Safety and Quality in Nursing Homes. (2020, July 7).
- ¹⁵⁴ McMichael, T. M., Clark, S., Pogojans, S., Kay, M., Lewis, J., Baer, A., Kawakami, V., Lukoff, M. D., Ferro, J., Brostrom-Smith, C., Riedo, F. X., Russell, D., Hiatt, B. Montgomery, P., Rao, A. K., Currie, D. W., Chow, E. J., Tobolowsky, F., Bardossy, A. C., ... (2020, March 18). *COVID-19 in a long-term care facility — King County, Washington, February 27–March 9, 2020*. *MMWR Morb Mortal Wkly* (Report 2020;69:339-342). <https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e1.htm>
- ¹⁵⁵ *Registered Nurse (RN) vs. Licensed Practical Nurse (LPN)*. (2020, August 13). RegisteredNursing.org. <https://www.registerednursing.org/rn-vs-lpn/>
- ¹⁵⁶ Coronavirus Commission for Safety and Quality in Nursing Homes (2020, July 1).
- ¹⁵⁷ *ANA nursing staffing requirements to meet the demands of today's long term care consumer*. (2014, November 12). American Nurses Association. <https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/id/nursing-staffing-requirements-to-meet-the-demands-of-todays-long-term-care-consumer/>
- ¹⁵⁸ In a few states, workforce members with equivalent competencies are Licensed Vocational Nurses (LVNs). Anywhere LPN appears in this document, LVN is implied.
- ¹⁵⁹ 42 CFR 483.80 (b)(3) “The facility must designate one or more individual(s) as the infection preventionist(s) (IPs) who are responsible for the facility's IPCP. The IP must: [. . .] (3) Work at least part-time at the facility . . .”
- ¹⁶⁰ Flynn, M. (2020, May 26). *How nursing homes can bolster infection control – for COVID-19 and beyond*. *Skilled Nursing News*. <https://skillednursingnews.com/2020/05/how-nursing-homes-can-bolster-infection-control-for-covid-19-and-beyond/>
- ¹⁶¹ U.S. Government Accountability Office. (2020, May 20). *Infection control deficiencies were widespread and persistent in nursing homes prior to COVID-19 pandemic*. <https://www.gao.gov/assets/710/707069.pdf>
- ¹⁶² Nursing home staff will need to be trained and supported in good infection control. Grabowski, D. C., & Mor, V. (2020). *Nursing Home Care in Crisis in the Wake of COVID-19*. *JAMA* 324(1), 23–24. doi: 10.1001/jama.2020.8524
- ¹⁶³ Centers for Medicare & Medicaid Services. (2020, July 22). *Trump administration announces new resources to protect nursing home residents against COVID-19* [Press release]. <https://www.cms.gov/newsroom/press-releases/trump-administration-announces-new-resources-protect-nursing-home-residents-against-covid-19>
- ¹⁶⁴ Centers for Medicare & Medicaid Services. (2020, February 6). *Information for healthcare facilities concerning 2019 novel coronavirus illness (2019-nCoV)*. <https://www.cms.gov/files/document/qso-20-09-all.pdf>
- ¹⁶⁵ Centers for Medicare & Medicaid Services. (2020, March 4). *Guidance for infection control and prevention of coronavirus disease 2019 (COVID-19) in nursing homes*. <https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and/qso-20-14-nh.pdf>
- ¹⁶⁶ Centers for Medicare & Medicaid Services. (2020, April 2). *COVID-19 long-term care facility guidance*. <https://www.cms.gov/files/document/4220-covid-19-long-term-care-facility-guidance.pdf>
- ¹⁶⁷ Centers for Medicare and Medicaid Services. (2020, May 13). *Toolkit on state actions to mitigate covid-19 prevalence in nursing homes*. <https://www.cms.gov/files/document/covid-toolkit-states-mitigate-covid-19-nursing-homes.pdf>
- ¹⁶⁸ Centers for Medicare & Medicaid Services. (2020, July 22). *Trump administration announces new resources to protect nursing home residents against COVID-19* [Press release]. <https://www.cms.gov/newsroom/press-releases/trump-administration-announces-new-resources-protect-nursing-home-residents-against-covid-19>
- ¹⁶⁹ Centers for Medicare & Medicaid Services. (2020, August 14). *Trump administration has issued more than \$15 million in fines to nursing homes during Covid-19 pandemic* [Press release]. <https://www.cms.gov/newsroom/press-releases/trump-administration-has-issued-more-15-million-fines-nursing-homes-during-covid-19-pandemic>
- ¹⁷⁰ Coronavirus Commission for Safety and Quality in Nursing Homes (2020, July 7).
- ¹⁷¹ Centers for Disease Control and Prevention. (2019, July 17). *Strategies to mitigate healthcare personnel staffing shortages*. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html>
- ¹⁷² Additional pay and support for staff, along with short-term programs to supplement this workforce, will be necessary. Grabowski, D. C., & Mor, V. (2020). *Nursing home care in crisis in the wake of COVID-19*. *JAMA*, 324(1), 23–24. doi:10.1001/jama.2020.8524

¹⁷³ Centers for Disease Control and Prevention. (2020, June 10). *The physiological burden of prolonged PPE use on healthcare workers during long shifts* [Blog]. <https://blogs.cdc.gov/niosh-science-blog/2020/06/10/ppe-burden/>

¹⁷⁴ If recent research does not exist, commission a study to establish this evidence base.

¹⁷⁵ MITRE-developed, derived from Commission discussion and/or public input.

¹⁷⁶ MITRE-developed, derived from Commission discussion and/or public input.

¹⁷⁷ State CMP funds may be reinvested to support activities that benefit nursing home residents and that protect or improve their quality of care or quality of life. Centers for Medicare & Medicaid Services. (2020, August 7). *Civil money penalty reinvestment program*. <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/LTC-CMP-Reinvestment>

¹⁷⁸ MITRE-developed, derived from Commission discussion and/or public input.

¹⁷⁹ MITRE-developed, derived from Commission discussion and/or public input.

3.7 Workforce Ecosystem: Strategic Reinforcement



The Commission identified three primary problems associated with workforce ecosystem strategic reinforcement.

1. CNAs spend more time with nursing home residents—including residents with additional COVID-19 care needs—than other members of the workforce, yet they earn the lowest wages among direct-care providers and receive few (if any) benefits.¹⁸⁰ CNA turnover rates can also be close to 100% in some cases.¹⁸¹ Moreover, the pandemic has disrupted CNA training critical for reinforcing the nursing home workforce, leading to serious CNA workforce deficits.¹⁸²
2. There are no national standards for training and licensure requirements of infection preventionists that nursing homes are mandated to employ.
3. Efforts to address workforce ecosystem challenges have been delayed, further jeopardizing an already fragile nursing home system. In addition to low pay and limited benefits, the potential of an emerging workforce is restrained by the combination of a lack of educational support (e.g., limited assistance in progressing into LPN/RN training), insufficient competency standards, low- to no exposure to geriatrics in formal education programs, and limited opportunities for professional advancement (e.g., no clinical ladder or lattice).¹⁸³

Response to Date and Emerging Evidence

CMS Actions to Date. CMS issued two blanket waivers addressing nursing assistant training and certification to reduce barriers for hiring and retaining CNAs.¹⁸⁴ The waivers provide flexibility at the federal level, but state occupational licensing and state regulatory agencies have to approve the temporary hiring of nursing assistants—and only certain states have done so.

Commission Member Discussions. Commission members highlighted throughout their convenings¹⁸⁵ that CMS must immediately launch a multi-faceted approach to strengthen the entire nursing home workforce pipeline in order to meet staffing-reinforcement needs in the near term.

Public Input. Public comments supported unified national training for nursing home staff, and called for additional funding to incentivize people to join and stay in the nursing home workforce.

Emerging Evidence. Deaths among nursing home staff during the pandemic illustrate how dangerous these jobs have become.¹⁸⁶ Future nursing home professionals must be equipped with knowledge,

“There should be more standardization of the curriculum across the country to make sure that the infection preventionist had (*sic*) adequate competency in this really important job.”

-Commission Member

skills, and resources to protect themselves and the residents for whom they will care, and immediate and ongoing systemic efforts must bolster workplace safety.

See [Appendix C](#) for additional detailed discussion of the emerging evidence and regulatory background.

Principal Recommendations and Action Steps

The Commission made four principal recommendations related to strategic reinforcements for the workforce.

Principal Recommendation 7A: Catalyze interest in the CNA profession through diverse recruitment vehicles; issue guidance for on-the-job CNA training, testing, and certification; and create a national CNA registry.

Action Steps

- Include content and relevant links related to CNA careers and certification in the administration’s “Find Something New” campaign website.¹⁸⁷
- Develop and implement a National CNA Community of Excellence recruitment campaign.
[Collaborate with CNA professional associations (e.g., National Association of Health Care Assistants (NAHCA))]
- Develop a public/private partnership with relevant industry partners and academia to promote and amplify the CNA Community of Excellence campaign.
- Permit nursing homes to hire personnel that are qualified to attend and complete CNA on-site, continuous training; and provide them with rigorous, on-site, developmentally and linguistically appropriate,¹⁸⁸ culturally mindful,¹⁸⁹ literacy-oriented^{190, 191} CNA training, testing, and certification using current (i.e., pre-waiver) state education standards and testing for nursing assistant certification. Involve residents, essential care partners, and family members as user experts complementing on-site instruction for CNAs in training.
- Require that nursing homes training CNAs on-site have these staff members work under supervision during their probationary period (i.e., until completion of their on-site training, testing, and certification); require nursing homes to track the progress of these staff members; and require nursing homes to recognize (e.g., graduation ceremony with residents in attendance) when CNAs have officially completed their on-site training, testing, and certification requirements.
- Assess targeted federal funds for on-site CNA training facilitation and materials; advise nursing homes how to access and distribute these funds.
- Monitor on-site training programs for CNAs and their subsequent performance to verify effectiveness (e.g., standard of care, retention rates, continued education).
[Collaborate with academia and foundations]

- Accurately track CNA workforce retention growth (e.g., individual continuing education and CNA profession growth).¹⁹²
[Collaborate with academia and the Bureau of Labor Statistics]

Principal Recommendation 7B: Professionalize infection prevention positions in nursing homes by updating regulations at 42 CFR § 483.80 so more fully qualified infection preventionists are available to serve in nursing homes.

Action Steps

- Leverage current training programs to develop and provide a standardized, required, regularly updated training curriculum and certification for infection preventionists in nursing homes at no cost to nursing homes. Consider using the following established programs:
 - CDC’s Nursing Home Infection Prevention Training Course
 - APIC materials, including:
 - EPI in Long-Term Care Certificate Program
 - EPI Intensive Certificate Program
 - Certified Infection Control (CIC) certification preparation materials, including the Infection Preventionist Certification Review Online Course
 - Basics of Infection Prevention and Control for Non-Clinicians Training Course
 - SHEA’s Podcast Series: Infection Control in Long-Term Care Facilities
 - SHEA/CDC Outbreak Response Training Program (ORTP)
 - Certification Board of Infection Control and Epidemiology’s (CBIC) CIC process
 - American Health Care Association’s (AHCA) Infection Preventionist Specialized Training
- Create a national registry of infection preventionists certified by this program to identify emergency reinforcement support for nursing homes without full-time infection prevention support.

Principal Recommendation 7C: Catalyze the overhaul of the workforce ecosystem in partnership with federal, SLTT, other public, private, and academic partners.

Action Steps

- Establish a competitive grant program and/or national scholarship to fund entry into practice education for aspiring CNAs.
[Collaborate with AHRQ]
- Identify and work to achieve funding mechanisms that defer/reimburse CNA and LPN education costs after three years of service in nursing homes.

- Identify and/or re-examine core competencies for long-term care direct-care providers; use these competencies to develop and/or update national training programs and standards (e.g., Nurse Aid National Training and Competency Evaluation Program). [Collaborate with CDC and OSHA]
- Modify RN, LPN, and CNA clinical training standards for certification and licensure; include a clinical rotation in a long-term care setting in order to supplement staffing and provide immersion into geriatric care and care for other specialty populations. [Collaborate with ANA, NAHCA, trade schools, universities, and state certification/licensure authorities]
- Develop a meaningful national clinical ladder and lattice for long-term direct care providers—including CNAs, LPNs, and RNs—that includes access to career advancement opportunities and improved compensation. [Collaborate with professional nursing associations and organizations]

Principal Recommendation 7D: Convene a Long-Term Care Workforce Commission to assess, advise on, and provide independent oversight for modernization of workforce ecosystem.¹⁹³

Action Step

- Develop a charter and criteria for identifying potential stakeholders to participate in the Long-Term Care Workforce Commission and/or Advisory Board.

Statement on Commission Endorsement

The recommendations and action steps of this theme have been endorsed by 22 members of the Commission; 2 members do not endorse Principal Recommendation 7A; 1 member does not endorse the report.

¹⁸⁰ PHI. (2019, September 3). *U.S. nursing assistants employed in nursing homes*. <https://phinational.org/resource/u-s-nursing-assistants-employed-in-nursing-homes-key-facts-2019/>

¹⁸¹ Quality Improvement Organizations. (2019, June). *Resources to support staff stability in post-acute and long-term care settings*. https://qioprogram.org/sites/default/files/editors/141/Resources_To_Support_Staff_Stability_20190626_508.pdf

¹⁸² Coronavirus Commission for Safety and Quality in Nursing Homes. (2020, July 14).

¹⁸³ Long-Term Care Commission Report; PHI. (2019, September 3). *U.S. nursing assistants employed in nursing homes*. <https://phinational.org/resource/u-s-nursing-assistants-employed-in-nursing-homes-key-facts-2019/>

¹⁸⁴ Centers for Medicare & Medicaid Services. (2020, March 6). *COVID-19 emergency declaration blanket waivers for health care providers*. <https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf>

¹⁸⁵ Coronavirus Commission for Safety and Quality in Nursing Homes (2020, July 7).

¹⁸⁶ McGarry, B., Porter, L., & Grabowski, D. (2020, July 28). *Nursing home workers now have the most dangerous jobs in America. They deserve better*. Washington Post.

<https://www.washingtonpost.com/opinions/2020/07/28/nursing-home-workers-now-have-most-dangerous-jobs-america-they-deserve-better/>

¹⁸⁷ MITRE-developed, derived from Commission discussion and/or public input.

¹⁸⁸ Gentry, R., Sallie, A., & Sanders, C. (2013). Differentiated instructional strategies to accommodate students with varying needs and learning styles. *The Urban Education Conference*. <https://files.eric.ed.gov/fulltext/ED545458.pdf>.

¹⁸⁹ Velott, D., Forte, K., S. (2019, March 5). Toward health equity: Mindfulness and cultural humility as adult education. *New Directions for Adult and Continuing Education*, 161, 57-66.

<https://onlinelibrary.wiley.com/doi/full/10.1002/ace.20311>

¹⁹⁰ Baur, C. (2011). Calling the nation to act: Implementing the national action plan to improve health literacy. *Nursing Outlook*, 59(2), 63-69. <https://www.sciencedirect.com/science/article/pii/S0029655410004793?viewFullText=true>

¹⁹¹ Egbert, N. & Nanna, K. (2009, September 30). Health literacy: Challenges and strategies. *OJIN*, 14(3).

<https://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol142009/No3Sept09/Health-Literacy-Challenges.html>

¹⁹² MITRE-developed, derived from Commission discussion and/or public input.

¹⁹³ MITRE-developed, derived from Commission discussion and/or public input.

3.8 Technical Assistance and Quality Improvement

Relates to Objectives



Scale of Public Input



The Commission identified the following primary problem associated with technical assistance and quality improvement.

1. To date, QIOs have begun assisting 9,000 of the 15,400 certified nursing homes in the country.^{194, 195} However, technical assistance and quality improvement support have not been sufficiently available at nursing homes during the pandemic. QIOs provide toolkits, information guides, and online learning options; nevertheless, nursing homes need proactive, tailored, timely, and on-the-ground support in emergency management, infection prevention and control, and workforce capability development.^{196, 197}

Response to Date and Emerging Evidence

CMS Actions to Date. Nursing homes with COVID-19 outbreaks receive on-site and online technical assistance and education.^{198, 199}

Commission Member Discussion.

Commission members recommended calling on QIOs to provide more on-site training and assistance to nursing homes—specifically those in infection hotspots—to improve resident care and outcomes. One commission member recommended increasing the number of QIOs so that each could serve a smaller segment of the country (and thus increase services to the smaller number of nursing homes).²⁰⁰ In addition, the Commission recommended creating COVID-19 QAPI tools for nursing homes.

Public Input. Public comments noted the lack of data reporting in some areas due to disincentives to report. Suggestions included a call for additional federal and state guidance with regard to ratings and survey processes for nursing homes to increase consistency and comparability.

Emerging Evidence. See [Appendix C](#) for additional detailed discussion of the emerging evidence and regulatory background.

“CMS should continue to hold routine discipline specific COVID-19 calls. These calls have provided a great opportunity for providers to hear directly from CMS as well as ask questions and raise pertinent issues, concerns or points of clarifications and receive responses in real time.”

-Public Input

Principal Recommendation and Action Steps

Principal Recommendation 8A: Identify and work to achieve funding mechanisms for—or reprioritize activities of—technical assistance providers and other contractors to increase the availability of collaborative, on-site, data-driven, and outcomes-oriented support prior to, during, and after a public health emergency.

Action Steps

- Redirect, prepare, and coordinate with regional strike teams, QIN-QIOs, and other technical assistance contractors to offer expanded, outcomes-oriented, on-the-ground technical assistance with organizational diagnosis, strategic direction, organizational resilience, resource prioritization, emergency-management assistance, data-management assistance, and workforce capability development in infection prevention and control, trauma-informed care, person-centered and person-directed care, visitation, and/or family communications and engagement.
- Research and provide examples of federal and regional strike teams providing technical assistance and quality improvement support.
- Support QIN-QIO technical assistance work with nursing homes and reinforce a culture of learning by grounding information about citations and penalties in QAPI methods.
- Create and distribute an organizational-level QAPI tool on how to effectively respond to COVID-19 and future pandemics.
- Remind nursing home administrators to use QAPI tools, data, and methods to improve their performance.
- Provide instruction to state surveyors on Focused Infection Control (FIC) rules and survey process, including information about when surveyors should provide nursing homes with immediate feedback.

"In this pandemic situation, we all have to take responsibility to collaborate and share learnings to get through this."

-Commission Member

Statement on Commission Endorsement

The recommendations and action steps of this theme have been endorsed by 23 members of the Commission; 1 member does not endorse Principal Recommendation 8A; 1 member does not endorse the report.

¹⁹⁴ Centers for Medicare and Medicaid Services. (2020, July 20). *Trump Administration Announces New Resources to Protect Nursing Home Residents Against COVID-19*. <https://www.cms.gov/newsroom/press-releases/trump-administration-announces-new-resources-protect-nursing-home-residents-against-covid-19>

¹⁹⁵ Centers for Medicare and Medicaid Services. (2020, August 25). *Trump Administration Launches National Training Program to Strengthen Nursing Home Infection Control Practices*. <https://www.cms.gov/newsroom/press-releases/trump-administration-launches-national-training-program-strengthen-nursing-home-infection-control>

¹⁹⁶ Coronavirus Commission for Safety and Quality in Nursing Homes. (July 7, 2020).

¹⁹⁷ Coronavirus Commission for Safety and Quality in Nursing Homes. (July 21, 2020).

¹⁹⁸ Centers for Disease Control and Prevention (2019). *Nursing Home Infection Preventionist Training Course*. www.cdc.gov/longtermcare/training.html

¹⁹⁹ Quality Improvement Organizations (2020). *CMS-CDC Fundamentals of COVID-19 Prevention for Nursing Home Management*. <https://qiopogram.org/demand-trainings-nursing-home-resources>

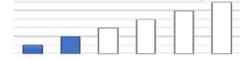
²⁰⁰ Coronavirus Commission for Safety and Quality in Nursing Homes. (July 7, 2020).

3.9 Facilities

Relates to Objectives



Scale of Public Input



The Commission identified two primary problems associated with nursing home facilities.

1. The physical environment (e.g., structure of resident rooms; architecture and layout of nursing homes; heating, ventilation, and air conditioning [HVAC] systems) of many nursing homes is not optimally designed to limit spread of transmissible diseases.²⁰¹
2. Fundamental design changes are costly and may take longer to implement, but are necessary due to the prolonged risks to residents from COVID-19 and the need to position facilities to manage future epidemics.

As the fall season approaches, design adaptation will take on increased importance and urgency with respect to physical-distancing practices that depend on use of outdoor space. Outdoor visitation, for example, will be neither safe nor practical in colder weather.

Response to Date and Emerging Evidence

CMS Actions to Date. CDC has issued iterative recommendations that nursing homes identify space in their facilities that could be dedicated to preventing and controlling COVID-19.²⁰² On July 9, CMS waived requirements under 42 CFR §483.90 to allow alternate facilities to be certified as SNFs in order to facilitate isolation of residents with COVID-19 disease.²⁰³ CMS guidance notes that the Medicare Conditions of Participation and interpretive guidance with respect to the Life Safety Code provide information regarding modifications to the physical plant to reduce infection risk.²⁰⁴

“When nursing homes are built, the ideal is private rooms with three fixture bathrooms. Of course, the expense of building that model is often prohibitive, so the infrastructure we have in place is often buildings from the 70’s with long institutional corridors and mostly semi-private rooms. Newer homes that are built try to include more privacy and a homelike character, but financing is difficult for this level of care, so compromises are made in order to build or renovate at all...”

-Public Input

Commission Member Discussions. During the Commission convenings,²⁰⁵ members spoke at length about the need for long-term solutions to improve the physical layout of nursing homes to better control the spread of communicable diseases. The Commission and public input alike highlighted the priority of single-occupancy rooms,²⁰⁶ but the current financial model does not support this. In the near term, the Commission noted the lack of physical space as a limitation to making changes to the physical layout. Additionally, the Commission noted that modifications or upgrades to HVAC systems and other adaptations are costly and would require supplemental funding in many cases.

Public Input. Public comments noted how design can support cohorting practices while maintaining the social and emotional health of residents.

Emerging Evidence. In a previous outbreak of a respiratory virus in a long-term care facility, lack of available space within the facility was identified as one of the challenges associated with cohorting symptomatic residents.²⁰⁷ Furthermore, a study of an influenza outbreak in a four-building nursing home suggested that current architectural design and HVAC systems may increase disease transmission.²⁰⁸ Out of four buildings, the influenza rate was lowest in the building with more space (square feet) per resident and featuring a unique HVAC system. Nursing home architecture and layout often prioritizes quality of life (e.g., establishing family units²⁰⁹) and resident safety (preventing falls²¹⁰ or wayfinding²¹¹) rather than infection prevention and control (e.g., single-occupancy rooms, improved HVAC systems). Designs should take into consideration psychosocial factors, physical safety, and infection prevention needs for residents. Design modifications made in response to COVID-19 ideally would not degrade or disrupt layout elements that promote quality of life and safety.

Principal Recommendations and Action Steps

The Commission made **three principal recommendations** in this area.

Principal Recommendation 9A: Identify and share with nursing homes short-term facility design enhancements to address immediate pandemic-related risks that can be implemented at minimal cost.

Action Steps

- Close information gaps on how to modify the physical plant by gathering best practices and issuing guidance on design enhancements.
[Collaborate with the CDC, the Environmental Protection Agency (EPA), and other federal partners]

Examples include:

- Resident rooms: The ability to physically separate residents is greatly enhanced when rooms are occupied by only a single resident.
- HVAC and air flow: modification and upgrades to HVAC systems further harden the infrastructure and potentially limit transmission.
- Work with CDC to supplement its guidance for the manipulation of HVAC systems that can reduce risk of transmission by:
 - Adjusting existing systems to support infection control (e.g., creating negative pressure, replacing filters)
 - Supplementing systems with equipment that can further purify air (e.g., air ionization, air scrubbers)

- Setting standards for HVAC system performance as part of the long-term plan to upgrade systems and redesign nursing homes
- Encourage nursing homes to assign residents to single-occupancy rooms in facilities that can accommodate this approach without detrimental reduction in census. Examine changes to the CMS reimbursement that would promote single occupancy (temporarily during pandemic as well as in the long term).

Principal Recommendation 9B: Establish a collaborative national forum to identify and share best practices and recommendations; facilitate real-time learning on how to best use existing physical spaces. (Please refer to action steps following 9C.)

Principal Recommendation 9C: Collaboratively establish long-term priorities and seek appropriate funding streams for nursing homes to redesign and/or strengthen facilities against infectious diseases.²¹²

Action Steps

- Establish a commission or task force, jointly led by industry, safety and consumer organizations, to identify long-term priorities for nursing care with emphasis on the design, redesign, retrofitting, and reconfiguration of nursing homes to be resilient to infectious disease threats.²¹³ Topics to be considered include, but are not limited to:
 - The ability to designate separate wings for cohorting
 - Separate entrances and exits
 - Separate restrooms and break areas for staff
 - Separate areas to don and doff PPE
 - Ultraviolet light systems for decontamination
 - HVAC upgrades and retrofitting
 - Design considerations that take resident quality of life and leisure into consideration
- Consider forming a public/private partnership that issues a challenge for nursing home redesign.²¹⁴

Statement on Commission Endorsement

The recommendations and action steps of this theme have been endorsed by 24 members of the Commission; 1 member does not endorse the report.

- ²⁰¹ Harrison, S. (2020, May 25). *Some nursing homes escaped COVID-19—Here's what they did right*. Wired. <https://www.wired.com/story/some-nursing-homes-escaped-covid-19-heres-what-they-did-right/>
- ²⁰² Centers for Disease Control and Prevention. (2020, June 25). *Preparing for COVID-19 in nursing homes*. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>
- ²⁰³ Centers for Medicare & Medicaid Services. (2020, July 9). *Long term care facilities (skilled nursing facilities and/or nursing facilities): CMS flexibilities to fight COVID-19*. <https://www.cms.gov/files/document/covid-long-term-care-facilities.pdf>
- ²⁰⁴ CMS technical input, August 26, 2020.
- ²⁰⁵ Coronavirus Commission for Safety and Quality in Nursing Homes (2020, July 7).
- ²⁰⁶ Plucinski, M.M., Wallace, M., Uehara, A., Kurbatova, E. V., Tobolowsky, F. A., Schneider, Z. D., Ishizumi, A., Bozio, C.H., Koboyashi, M., Toda, M., Stewart, A., Wagner, R. L., Moriarty, L. F., Murray, R., Queen, K., Tao, Y., Paden, C., Mauldin, M. R., Zhang, J., (2020, August 12). COVID-19 in Americans aboard the Diamond Princess cruise ship [Accepted manuscript]. *Clinical Infectious Diseases*. <https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciaa1180/5891779#.XzmzSCFyVfg.twitter>
- ²⁰⁷ Spires, S. S., Talbot, H. K., Pope, C. A., & Talbot, T. R. (2017). Paramyxovirus outbreak in a long-term care facility: The challenges of implementing infection control practices in a congregate setting. *Infection Control and Hospital Epidemiology*, 38(4), 399-404. doi: <https://10.1017/ice.2016.316>
- ²⁰⁸ Drinka, P. J., Krause, P., Schilling, M., Miller, B. A., Shult, P., & Gravenstein, S. (1996). Report of an outbreak: Nursing home architecture and influenza-A attack rates. *Journal of the American Geriatrics Society*, 44(8), 910-30. <https://pubmed.ncbi.nlm.nih.gov/8708299/>
- ²⁰⁹ Chang, Y. P., Li, J., & Porock, D. . (2013). The effect on nursing home resident outcomes of creating a household within a traditional structure. *Journal of the American Medical Directors Association*, 14(4), 293-99. <https://pubmed.ncbi.nlm.nih.gov/23434319/>
- ²¹⁰ Hill, E. E., Nguyen, T. H., Shaha, M., Wenzel, J. A., DeForge, B. R., & Spellbring, A. M. . (2009 October). Person-environment interactions contributing to nursing home resident falls. *Research in Gerontological Nursing*, 2(4), 287-96. <https://pubmed.ncbi.nlm.nih.gov/20077985/>
- ²¹¹ Marquadt, G. (2011). Wayfinding for people with dementia: a review of the role of architectural design. *HERD* 4(2), 75-90. <https://pubmed.ncbi.nlm.nih.gov/21465436/>
- ²¹² MITRE-developed, derived from Commission discussion and/or public input.
- ²¹³ MITRE-developed, derived from Commission discussion and/or public input.
- ²¹⁴ MITRE-developed, derived from Commission discussion and/or public input.

3.10 Nursing Home Data



The Commission identified three primary problems associated with nursing home data.

1. The time and cost required for nursing homes to report COVID-19-related data to the federal government is not consistently offset by benefits to nursing home residents, families, or staff. For example, nursing homes continue to lack sufficient PPE despite reporting these shortages to CMS.²¹⁵
2. Nursing homes are required to report multiple types of data to various federal and state authorities, which is complex and time-consuming. In addition, data and information released to nursing homes by CMS and its federal partners has been at times inconsistent, and released and accessible via multiple websites. These issues make it challenging for nursing homes to comply with reporting requirements, and difficult for staff to be sure they are accessing the most relevant, trustworthy, and up-to-date data and guidance. The situation continues to rapidly evolve, and some initial efforts have been made by CMS and its federal partners to consolidate information. Nevertheless, a more cohesive approach is needed to streamline data collection and information dissemination.²¹⁶
3. The lack of consistent nursing home data standards and interoperability can hinder data management and data sharing between providers and payers, delay effective care delivery, and result in poor data integration across care settings.^{217, 218} Further discussion of data limitations related to nursing homes appears at [Appendix H](#).

Response to Date and Emerging Evidence

CMS Actions to Date. Findings from a Government Accountability Office report noted the need for CMS to make ongoing improvements in how nursing home data are collected, compiled, and reported publicly.²¹⁹ CMS has taken some steps to address these issues, including updating the CMS Nursing Home Compare website and Five-Star Quality Rating System.^{220, 221} CMS and CDC are refining and creating greater specificity for certain COVID-19 NHSN data elements, such as gathering more details related to testing.²²² Furthermore, CMS and its federal partners are taking action based on data that nursing homes report to the NHSN system. Between July 18 – 20, CMS and federal partners began deploying Task Force Strike Teams to provide technical assistance to select nursing homes with increased cases.²²³ CMS is also using this data as part of the weekly “Governor’s report” so that states can direct support to the highest-risk nursing homes.²²⁴ Data from state and local health departments will continue to be important as well. CMS and CDC established a resource that provides access to the COVID-19 Public File containing data reported by nursing homes to NHSN, as well as related resources and statistics.²²⁵ CMS has released iterative guidance requiring facilities to report information about communicable diseases, healthcare-associated infections, and potential outbreaks to CDC in a standardized format.^{226, 227} CMS also requires nursing homes to report COVID-19 facility data to the CDC as well as residents, their representatives, and their families. Further, CMS updated several surveys and related tools to reflect COVID-19 reporting requirements.²²⁸

Commission Member Discussions. Commission members²²⁹ supported obtaining data from, and releasing information to, nursing homes that can be acted upon in a meaningful way, while also considering the associated time and costs of data collection.

During a Commission convening on July 29, CMS reported that it has begun developing a new consolidated source of guidance and other relevant information.²³⁰ Commission members generally supported efforts to develop a central location for nursing homes to submit COVID-19 data, and to find essential information from CMS and its federal partners.

Public Input. Public comments noted the importance of providing a centralized collection and reporting hub for easy access by stakeholders looking to make informed and coordinated decisions. Other input focused on the importance of providing additional data context to enhance predictive ability of nursing homes for planning and coordination with other health facilities.

Emerging Evidence. See [Appendix C](#) for additional discussion of the emerging evidence and regulatory background.

Principal Recommendations and Action Steps

The Commission made **three principal recommendations** to improve the availability and usefulness of nursing home data.

Principal Recommendation 10A: Standardize COVID-19 data elements, improve data collection, and identify supportive actions that CMS and federal partners will take in response to key COVID-19 indicators based on nursing home-reported data.

Action Steps

- Further standardize existing data elements, improve current survey questions,²³¹ and incorporate additional elements into the NHSN dataset that are essential for improved clinical outcomes and quality care delivery but not yet adequately captured in other existing reporting systems (e.g., MDS and PBJ). This data may include turnaround times on diagnostic tests, infection-control measures, and detailed staffing data (e.g., staff providing housekeeping services).
[Collaborate with CDC]
- Capture more-targeted data and identify corresponding actions related to the experiences, perspectives, and other issues shared by residents, families, and staff. Focus on data related to demographics, visitation, satisfaction, quality of life, depression, and basic behavioral needs (e.g., resident access to a phone).
- Develop threshold criteria for key data indicators (e.g., positive COVID-19 test results, deaths, low PPE supplies, staffing requirements) that will trigger coordinated responses by CMS, state and federal partners, and nursing homes. These indicator thresholds should

“[We need] streamlining of multiple guidance on state and federal level, as well as reporting. And if we can achieve this, that would free up resources to really do some of the other items that have been identified throughout [this commission].”

-Commission Member

be integrated into relevant policies and updated based on evolving evidence.²³²
[Collaborate with state and local authorities]

- Leverage actionable NHSN data about equipment and supplies to assist with coordination of available resources and support for screening, testing, cohorting, training, and equipment needs at a national level.
- Provide clear guidance on appropriate uses of data to support facilities while recognizing the need to ensure quality and safety standards.
- Collect and analyze COVID-19 data that was reported by nursing homes to state and local authorities during the period from the beginning of the pandemic until the nationally required reporting of these data to the NHSN system was formally mandated on May 8. Establish a national data clearinghouse to make this data and its analysis available to the research community and general public. As feasible, include in this clearinghouse additional data for this timeframe that nursing home owners and administrators may voluntarily share directly with the clearinghouse.²³³
[Collaborate with CDC and other federal partners]

Principal Recommendation 10B: Create an easy-to-use, intuitive, and interactive technical infrastructure for nursing homes that streamlines the process of data reporting and consolidates dissemination of essential policy guidance, information about updated regulations, and other communications.

Action Steps

- Define and prioritize features and capabilities of the new streamlined technical infrastructure.²³⁴
[Collaborate with health information technology (HIT) resources, vendors, and nursing home owners and administrators]
- Develop a secure method for nursing homes to enter new data and correct previously submitted data.
- Provide dynamic, real-time, mobile-friendly, HIPAA-compliant, and actionable feedback reports to nursing homes and federal partners based on the data entered or queried. The reporting elements should include, but are not limited to, clinical and performance metrics, resource utilization, survey responses, inspection data, and information related to the well-being of residents.
- Integrate a COVID-19 toolkit into the technical infrastructure to include an interactive map of states with the current applicable metrics, mandates, and guidance.

Principal Recommendation 10C: Enhance HIT interoperability to facilitate better communication, improve quality measurement standards, and coordinate integration of nursing home data with data from other health organizations.

Action Steps

- Develop interoperability and communication standards to integrate nursing home data with data from other health organizations, as demonstrated by ONC’s Health IT Certification Program in the electronic health record (EHR) market.²³⁵
[Collaborate with the Office of the National Coordinators for Health Information Technology (ONC)]
- Incentivize nursing homes to adopt health information technology (HIT) to standardize data collection, transmission, and management to support health information exchange and access to comprehensive EHRs by care providers across settings. (*Note: A Commission member does not support incentives for the use of HIT; since it is not new, its adoption should be a business decision on the part of the owners and administrators.*)
- Promote interoperability standards across nursing homes.
- Assess data needs and leverage data assets.
[Collaborate with state and local authorities]
- Foster collaboration, data transparency, and information-sharing across health organizations and information technology vendors. (*Note: Some Commission members feel strongly that if nursing homes are encouraged to contribute to data transparency, CMS should ensure protection of the facilities and healthcare providers through federal rules.*)

Statement on Commission Endorsement

The recommendations and action steps of this theme have been endorsed by 24 members of the Commission; 1 member does not endorse the report.

²¹⁵ Rau, J. (2020, June 11). *Nursing homes run short of covid-19 protective gear as federal response falters*. NPR. <https://www.npr.org/sections/health-shots/2020/06/11/875335588/nursing-homes-run-short-of-covid-19-protective-gear-as-federal-response-falters>

²¹⁶ Coronavirus Commission for Safety and Quality in Nursing Homes. (2020, July 21).

²¹⁷ Mohamoud, S., Byrne, C., & Samarth, A. (2009, October). *Implementation of health information technology in long-term care settings: Findings from the health it portfolio*. Agency for Healthcare Research and Quality. <https://digital.ahrq.gov/sites/default/files/docs/page/08-0087-EF.pdf>

²¹⁸ Heny, J., Pylpchuk, Y., & Patel, V. (2018, November). *Electronic health record adoption and interoperability among U.S. skilled nursing facilities and home health agencies in 2017* (Report No. 41). The Office of the National Coordinator for Health Information Technology. <https://www.healthit.gov/sites/default/files/page/2018-11/Electronic-Health-Record-Adoption-and-Interoperability-among-U.S.-Skilled-Nursing-Facilities-and-Home-Health-Agencies-in-2017.pdf?platform=hootsuite>

²¹⁹ Dicken, J. E. (2018, September 6). *Nursing home quality: Continued improvements needed in CMS’s data and oversight*. Government Accountability Office. <https://www.gao.gov/assets/700/694324.pdf>

²²⁰ Centers for Medicare & Medicaid Services. (2019, March 5). *CMS improving nursing home compare in April 2019* [Press release]. <https://www.cms.gov/newsroom/press-releases/cms-improving-nursing-home-compare-april-2019>

- ²²¹ Wright, D. (2019, October 7). *Consumer alerts added to the Nursing Home Compare website and the Five Star Quality Rating System*. Centers for Medicare and Medicaid Services. <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO-20-01-NH.pdf>
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- ²²³ Centers for Medicare & Medicaid Services. (2020, July 22). *Trump administration announces new resources to protect nursing home residents against COVID-19* [Press release]. <https://www.cms.gov/newsroom/press-releases/trump-administration-announces-new-resources-protect-nursing-home-residents-against-covid-19>
- ²²⁴ Ibid.
- ²²⁵ Ibid.
- ²²⁶ Wright, D. R. (2020, March 13). *Guidance for infection control and prevention of coronavirus disease 2019 (COVID-19) in nursing homes (REVISED)*. Centers for Medicare & Medicaid Services. <https://www.cms.gov/files/document/3-13-2020-nursing-home-guidance-covid-19.pdf>
- ²²⁷ Wright, D. R. (2020, April 19). *Upcoming requirements for notification of confirmed COVID-19 (or COVID-19 persons under investigation) among residents and staff in nursing homes*. Centers for Medicare & Medicaid Services. <https://www.cms.gov/files/document/qso-20-26-nh.pdf>
- ²²⁸ Wright, D. R. (2020, May 6). *Interim final rule updating requirements for notification of confirmed and suspected covid-19 cases among residents and staff in nursing homes*. Centers for Medicare and Medicaid Services. <https://www.cms.gov/files/document/qso-20-29-nh.pdf>
- ²²⁹ Coronavirus Commission for Safety and Quality in Nursing Homes (2020, July 21).
- ²³⁰ Coronavirus Commission for Safety and Quality in Nursing Homes. (2020, July 29).
- ²³¹ An example of an improvement offered by a Commission member would be to the NHSN survey of facilities around testing, PPE, and staffing. The PPE and staffing questions only measure extreme shortages. Commission member feedback to draft report, August 24, 2020.
- ²³² MITRE-developed, derived from Commission discussion and/or public input.
- ²³³ Emergency Support for Nursing Homes and Elder Justice Reform Act of 2020, S. 4182, 116 Cong., 2d Sess. (2020). <https://www.finance.senate.gov/imo/media/doc/116.S.4182%20-%20Emergency%20Nursing%20Home%20Relief%20and%20Elder%20Justice%20Reform%20Act%20of%202020%20bill%20text.pdf>
- ²³⁴ MITRE-developed, derived from Commission discussion and/or public input.
- ²³⁵ MITRE-developed, derived from Commission discussion and/or public input.

4 Securing the Future of Long-Term Care

The Commission based its work on lessons learned from the early days of the pandemic, and it envisions future actions by CMS and its federal partners to improve infection prevention and control, safety, and quality within nursing homes. Unless accompanied by sustainable, systems-level change addressing the issues discussed in the report ([Background](#)), however, these recommendations will likely be inadequate to enable nursing homes to prevent the next crisis. Nursing homes (and long-term care in general) need to be reimaged to ensure they can protect the safety and foster the well-being of some of the most vulnerable members of our population—older adults and people with disabilities. This conclusion discusses five key areas for long-term improvement.

4.1 Strategic Workforce Planning

It is impossible to ensure quality care for and safety of residents without first supporting their direct-care providers. Strengthening the nursing home workforce and supporting other resident care partners involves many dimensions, but a primary area of focus must be CNAs. These professionals serving on the front lines of care delivery are generally underpaid, receive few if any benefits, and have little to no opportunity for career advancement.

The Commission recommends that CMS partner with experts across government components (federal and SLTT), private leaders, and academic experts to convene a Strategic CNA Workforce Planning Council that will realize the promise of the data-driven, CNA-oriented advice that may emerge from the proposed Long-Term Care Commission ([Section 3.7](#)). This new council should work to articulate the present and future projections for CNAs, and develop a plan for training, recruitment, retention, and growth for these professionals. The council should also assess the cultural aspects that disincentivize and devalue the prospect of working in a nursing home. Commission members often remarked that the outside world does not value the labor and investment of CNAs and other providers, thus contributing to their turnover. Therefore, this strategic CNA workforce planning should encompass extrinsic and intrinsic benefits alike, especially within the context of the entire workforce system.

With CMS leading these actions, the CNA workforce of the future will be more competent, more capable of providing high-quality care, and encouraged to remain in these roles or to grow along a career track, actualized by the satisfaction they derive from the meaningful work they contribute to residents, their families, and our society.

4.2 Interoperable Data, Real-Time Predictive Modeling, and Communications Technology

The United States needs to develop a national strategy to improve the data available within and across nursing homes. Data about residents and facilities is often siloed and incomplete. Nursing homes (especially independent ones) are often under-resourced to address these issues. Technology within nursing homes is often outdated and insufficient, hindering not only data-related activities of staff but also communications that may provide vital linkages between residents and the larger community. Many nursing homes will need coordinated federal and

SLTT support (including funding) to bring their systems and capabilities in line with the 21st century.

Assessing quality and outcomes in any healthcare setting depends on accurate and comprehensive data. During the pandemic, some stakeholders proposed collecting additional data, such as leveraging the existing MDS for SNF residents to capture data specific to COVID-19.²³⁶ COVID-19 highlighted the immediate need for better and more timely data related to care processes, staffing, infection rates, deaths, and other issues; nevertheless, nursing homes are also lagging in use of EHRs and interoperability of data. SNFs were not eligible to participate in the Medicare and Medicaid Promoting Interoperability Programs; in 2017, 66% of SNFs had adopted EHRs, and only 18% of SNFs had the ability to integrate resident health information received from outside facilities.²³⁷

A more complete picture of the health and well-being of residents at a population level across the varied sites where care and services are received would assist with rapid identification of insights and evidence for improvements that help prevent and treat infections more effectively and efficiently - now and in the future. Such data could also be used to predict hotspots, resource needs, and other interventions in the future, thus protecting residents before threats occur. Data could also be used to further research in long-term care.

With CMS taking a lead, in collaboration with its federal partners, to drive these changes, nursing home owners and administrators will be able to more fully leverage modern technology to: 1) integrate with the larger healthcare data network, yielding an enrichment of the big data analytics needed to formulate systems-level, data-driven decisions, and 2) engage in user-centered communications with their staff, residents, residents' representatives and families, and the public, yielding a greater sense of transparency, accountability, and partnership.

4.3 Facility Planning and Renovations

Throughout the pandemic, outdated facilities have complicated the challenges that nursing homes face to meet the needs of residents while protecting them from infectious diseases. Facilities cannot easily be retrofitted for cohorting or creating separate visitor entrances. CMS needs to examine how nursing homes are financed; fixed costs may prevent owners and administrators from investing in infrastructure stabilization and modernization. CMS is positioned to elicit recommendations for the redesign, retrofitting, and reconfiguration of nursing homes that incorporate lessons learned about disease prevention and control; technological best practices; financing requirements; and the health and well-being of residents and staff. These recommendations could be collected by a sub-committee of the proposed Long-Term Care Commission ([Section 3.7](#)).

By catalyzing this change, CMS will help ensure that nursing home stakeholders of the future will feel safe, secure, and supported in the environments where they live and work.

4.4 Payment Reform

Across the care continuum, payment drives care. Payment in the long-term care setting is split across payers and systems—too often incentivizing the type of care received, rather than coordinated best practices for quality and safety. CMS, together with its partners, must undertake

payment reform, specifically clarifying coverage for resident hand-offs across a wide variety of care settings. CMS, with its government, private, and academic partners, can recommend concrete payment-reform options that incentivize coordinated, personalized care that prioritizes safety and quality.²³⁸ These recommendations could be collected by a sub-committee of the proposed Long-Term Care Commission ([Section 3.7](#)).

By CMS leading these actions, nursing home residents of the future will feel they are actually at the center of and driving decision-making about their care and well-being.

4.5 Overall: Resident-Driven Care and Shared Decision-Making

These system reforms must be made in a resident-centered and, if possible, resident-driven manner. Resident-driven care prioritizes not only clinical care received, but also the lifestyle goals of the resident—where they live, with whom they live, their quality of life, their visitor preferences, their desires, and ability to leave, and so on. It recognizes residents for who they are—human beings who should be treated with dignity and respect; who deserve to not only be a part of those decisions but to be armed with information to help drive those decisions.

CMS should take every recommended action—and all of its work on behalf of nursing homes—with this resident-centered and resident-directed focus in mind. The nation’s attention has landed squarely on nursing homes during this pandemic. America is witnessing the devastating consequences of having ignored or underfunded systemic issues in long-term care settings. We envision a system of care that is better for our children than it is and was for our grandparents—one that values and respects older adults and people with disabilities as vital to the fabric of our society.

²³⁶ Fogel, B. S. (2020, July 27). Data Driven Solutions For COVID-19 in Skilled Nursing Facilities: MDS ‘Section Y’. *Health Affairs*. <https://www.healthaffairs.org/doi/10.1377/hblog20200723.64590/full/>

²³⁷ Heny, J., Pylpchuk, Y., & Patel, V. (2018, November). *Electronic Health Record Adoption and Interoperability among U.S. Skilled Nursing Facilities and Home Health Agencies in 2017*. The Office of the National Coordinator for Health Information Technology. <https://www.healthit.gov/sites/default/files/page/2018-11/Electronic-Health-Record-Adoption-and-Interoperability-among-U.S.-Skilled-Nursing-Facilities-and-Home-Health-Agencies-in-2017.pdf>

²³⁸ See Commission on Long-Term Care (September 30, 2013). “Report to the Congress.” <http://ltccommission.org/ltccommission/wp-content/uploads/2013/12/Commission-on-Long-Term-Care-Final-Report-9-26-13.pdf>

Appendix A: Definition of Acronyms and Terms in Report

1. Acronyms

Acronym	Definition
AHCA	American Health Care Association
AHRQ	Agency for Healthcare Research and Quality
APIC	Association for Professionals in Infection Control
ASPR	Assistant Secretary for Preparedness and Response
CARES Act	Coronavirus Aid, Relief, and Economic Security Act
CBIC	Certification Board of Infection Control and Epidemiology
CDC	Centers for Disease Control and Prevention
CFR	Code of Federal Regulations
CGNO	Coalition of Geriatric Nursing Organizations
CHIP	Children's Health Insurance Program
CIC	Certified Infection Control
CLIA	Clinical Laboratory Improvement Amendments
CMP	Civil Monetary Penalty
CMS	Centers for Medicare & Medicaid Services
CNA	Certified Nursing Assistant
COVID	Coronavirus Disease
COVID-19	Coronavirus Disease-2019
ECP	Essential Care Partner
EHR	Electronic Health Record
EPA	Environmental Protection Agency
ESBL	Extended Spectrum Beta-Lactamase
FAQ	Frequently Asked Question
FDA	Food and Drug Administration
FEMA	Federal Emergency Management Agency
FFRDC	Federally Funded Research and Development Center
FIC	Focused Infection Control

Acronym	Definition
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
HPSA	Health Professional Shortage Area
HVAC	Heating, Ventilation, and Air Conditioning
IP	Infection Prevention
IPC	Infection Prevention and Control
IPCP	Infection Prevention and Control Program
LPN	Licensed Practical Nurse
LTC	Long-Term Care
LTCCR	Long Term Care Commission Report to Congress
LTSS	Long-Term Services and Supports
MDS	Minimum Data Set
MITRE	The MITRE Corporation
MMWR	Morbidity and Mortality Weekly Report
MRSA	Methicillin-resistant Staphylococcus aureus
NAHCA	National Association of Health Care Assistants
NASEM	National Academy of Sciences, Engineering, and Medicine
NCAL	National Center for Assisted Living
NCIRD	National Center for Immunization and Respiratory Diseases
NF	Nursing Facility
NHSN	National Healthcare Safety Network
NIH	National Institutes of Health
NIOSH	National Institute for Occupational Safety and Health
NPI	Non-Pharmaceutical Interventions
OASH	Office of the Assistant Secretary for Health
PPE	Personal Protective Equipment
PUF	Public Use File
QAPI	Quality Assurance and Performance Improvement
QIN	Quality Improvement Network

Acronym	Definition
QIO	Quality Improvement Organization
RAI/MDS	Resident Assessment Instrument/Minimum Data Set
RN	Registered Nurse
SARS	Severe Acute Respiratory Syndrome
SARS-CoV-2	Severe Acute Respiratory Syndrome Coronavirus 2
SEAN	National Academies of Sciences, Engineering, and Medicine Societal Experts Action Network
SHEA	Society for Healthcare Epidemiology of America
SLTT	State, Local, Territorial, and Tribal
SNF	Skilled Nursing Facility
TB	tuberculosis
USC	United States Code
USPHC	United States Public Health Service Corps
VRE	Vancomycin-resistant Enterococci
WHO	World Health Organization

2. Glossary of Terms

Term	Definition
The Act	The Social Security Act
Amendment	In the final privacy rule, an amendment to a record would indicate that the data is in dispute while retaining the original information (CMS).
Office of the Assistant Secretary for Preparedness and Response (ASPR)	From phe.gov: ASPR was established to create a focal point or a “unity of command” by consolidating all Federal nonmilitary public health and medical preparedness and response functions in one office. ASPR leads the public health and medical, preparedness, response and recovery to disasters and public health emergencies.
Assessments	The gathering of information to rate or evaluate your health and needs, such as in a nursing home.

Term	Definition
Asymptomatic Carrier	From CDC.gov: An individual who tests positive for COVID-19 but does not exhibit the known symptoms of the disease.
Blanket waiver	Under Section 1135 or 1812(f) of the Social Security Act, CMS can issue several blanket waivers when there is a disaster or emergency. When a blanket waiver is issued, providers are not required to apply for an individual waiver. Blanket waivers prevent access to care gaps for beneficiaries affected by the emergency. If a blanket waiver is not issued, providers can ask for an individual Section 1135 waiver.
Center for Disease Control and Prevention (CDC)	From CDC.gov: The Centers for Disease Control and Prevention (CDC) serves as the national focus for developing and applying disease prevention and control, environmental health, and health promotion and health education activities designed to improve the health of the people of the United States.
Certified Nursing Assistant (CNA)	From bls.gov: Nursing assistants provide basic care and help residents with activities of daily living.
Civil Money Penalty (CMP)	A CMP is a monetary penalty the Centers for Medicare & Medicaid Services (CMS) may impose against nursing homes for either the number of days or for each instance a nursing home is not in substantial compliance with one or more Medicare and Medicaid participation requirements for long-term care facilities. A portion of CMPs collected from nursing homes are returned to the states in which CMPs are imposed. State CMP funds may be reinvested to support activities that benefit nursing home residents and that protect or improve their quality of care or quality of life.
Clinical Laboratory Improvement Amendments (CLIA)	The Centers for Medicare & Medicaid Services (CMS) regulates all laboratory testing (except research) performed on humans in the U.S. through the Clinical Laboratory Improvement Amendments (CLIA). In total, CLIA covers approximately 260,000 laboratory entities. The objective of the CLIA program is to ensure quality laboratory testing. Although all clinical laboratories must be properly certified to receive Medicare or Medicaid payments, CLIA has no direct Medicare or Medicaid program responsibilities.
CMS Locations	CMS sites formerly referred to as Regional Offices.

Term	Definition
Cohorting	Cohorting is the process of locating individuals with the same condition in the same space with the intent of reducing or eliminating interaction between infected persons with uninfected persons.
Commission members	The people selected by MITRE to serve on the Commission.
Contact tracing	From CDC.gov: Case investigation and contact tracing are fundamental activities that involve working with a person (symptomatic and asymptomatic) who has been diagnosed with an infectious disease to identify and provide support to people (contacts) who may have been infected through exposure to the person.
Convenings	Meetings of The Coronavirus Commission for Safety and Quality in Nursing Homes
Coronavirus Aid, Relief, and Economic Security Act (CARES Act)	From treasury.gov: The Coronavirus Aid, Relief, and Economic Security (CARES) Act was signed into law by President Trump on March 27th, 2020. The CARES Act provides for payments to State, Local, and Tribal governments navigating the impact of the COVID-19 outbreak. CMS received \$5 billion from the Provider Relief Fund authorized by the CARES Act for nursing homes' use.
Coronavirus Disease 2019 (COVID-19)	The disease caused by SARS-CoV-2
Decontamination	From CDC.gov: Decontamination of N95 Filtering Facepiece Respirators (FFRs) may be considered as part of limited reuse strategies. Extended use may also be considered as part of limited reuse strategies whereby an N95 FFR is worn for multiple person contacts then stored or decontaminated before being reused.
Diagnostic test	Diagnostic testing is used to identify infected individuals based on the ability to detect the presence of the genetic signature of the SARS-CoV-2 virus in respiratory secretions.
Don and Doff	From CDC.gov: Don is the process of how to put on PPE gear while Doff is the process of how to take off PPE.
Emergency Preparedness Rule, 42 C.F.R. § 483.73	The long-term care facility must comply with all applicable Federal, State and local emergency preparedness requirements. The long-term care facility must establish and maintain an emergency preparedness program that meets the requirements of this section.

Term	Definition
Family	For the purposes of this report, anyone the resident defines as their family, individuals who are related to them, as well as friends.
Federal Emergency Management Agency (FEMA)	From FEMA.gov: FEMA's mission is to help people before, during and after disasters.
Federally Funded Research and Development Center (FFRDC)	The FFRDC works with federal government sponsors as a technical collaborator and advisor on critical research and development programs and technology acquisitions.
Focused Infection Controls (FIC) Survey	The Focused Infection Control Survey is a CMS Assessment tool used by federal and state surveyors to assess compliance with the minimum health and safety requirements as it relates to the COVID-19 pandemic. It is available to every provider in the country to make them aware of Infection Control priorities during this time of crisis, and providers and suppliers may perform a voluntary self-assessment of their ability to meet these priorities.
Food and Drug Administration (FDA)	From FDA.gov: The FDA is responsible for ensuring that human drugs, and vaccines and other biological products and medical devices intended for human use are safe and effective.
Hazard Pay	From DOL.gov: Hazard pay means additional pay for performing hazardous duty or work involving physical hardship. Work duty that causes extreme physical discomfort and distress which is not adequately alleviated by protective devices is deemed to impose a physical hardship. The Fair Labor Standards Act (FLSA) does not address the subject of hazard pay, except to require that it be included as part of a federal employee's regular rate of pay in computing the employee's overtime pay.
Healthcare Personnel	From CDC.gov: Healthcare personnel (HCP) refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to clients/residents/patients or infectious materials
Health Information Technology (HIT)	From HealthIT.gov: The application of information processing involving both computer hardware and software that deals with the storage, retrieval, sharing, and use of healthcare information, data, and knowledge for communication and decision making.

Term	Definition
Health Professional Shortage Areas (HPSA)	From HRSA.gov: Health Professional Shortage Areas (HPSAs) are designations that indicate healthcare provider shortages in primary care, dental health; or mental health. These shortages may be geographic-, population-, or facility-based.
HIPAA compliant	A regulation to guarantee people's rights and protections against the misuse or disclosure of their health records.
COVID-19 Hotspot	From CDC.gov: Counties meeting specified criteria relating to temporal increases in number of cases and incidence.
Infection Prevention and Control Programs (IPCP) 42 CFR § 483.80	The long-term care facility must establish an infection prevention and control program (IPCP).
Infection Prevention Educators	Provide and document competency-driven, experiential training on core practice; crisis standards of care, including fit testing of N95 masks and PPE donning and doffing; and crisis recovery; and regularly assess competency achievement of all direct and contract staff (e.g., administrators, nurses, CNAs, environmental services, maintenance, food service, and ancillary staff).
Long-Term Care	Health-related care and services (above the level of room and board) not available in the community, needed regularly due to a mental or physical condition
Long-term care facilities	Used when referring collectively to skilled nursing facilities, nursing facilities, assisted living facilities, and other facilities that provide long-term care.
Long-Term Services and Supports	The Centers for Medicare & Medicaid Services (CMS) is working in partnership with states, consumers and advocates, providers and other stakeholders to create a sustainable, person-driven long-term support system in which people with disabilities and chronic conditions have choice, control and access to a full array of quality services that assure optimal outcomes, such as independence, health and quality of life.
Medicaid Beneficiaries	Individuals eligible to receive healthcare services paid by Medicaid; 10.9 million individuals are dually eligible for Medicare and Medicaid.

Term	Definition
Medicare Beneficiaries	58 million individuals who are eligible to receive Medicare benefits from CMS; individuals ages 65 and older, individuals under age 65 who are receiving disability benefits from Social Security or the Railroad Retirement Board, and those having End Stage Renal Disease.
National Healthcare and Safety Network (NHSN)	From CDC.gov: CDC's National Healthcare Safety Network is the nation's most widely used healthcare-associated infection (HAI) tracking system. NHSN provides facilities, states, regions, and the nation with data needed to identify problem areas, measure progress of prevention efforts, and ultimately eliminate healthcare-associated infections.
Non-pharmaceutical intervention (NPI)	Interventions to slow the spread of SARS-CoV-2, excluding medication (e.g., mandatory stay at home orders; non-essential business closures; social distancing; large gathering bans; school closures; mandatory isolation of the sick; mandatory quarantine of travelers; and restrictions on bars, restaurants, and other public places
Nursing facility (NF)	A facility that provides long-term medical and skilled nursing care, rehabilitation, or health-related services; Medicaid is the dominant payer
Nursing home	The type of facility that is the focus of the Commission's work; including both skilled nursing facilities and nursing facilities.
Nursing home residents	People who reside in nursing homes.
Observation Unit	A separate area in a nursing home for newly admitted or transferred residents
Ombudsman	From acl.gov: States' Long-Term Care Ombudsman programs work to resolve problems related to the health, safety, welfare, and rights of individuals who live in long-term care facilities, such as nursing homes, board and care and assisted living facilities, and other residential care communities. Ombudsman programs promote policies and consumer protections to improve long-term services and supports at the facility, local, state, and national levels.
Outbreak	From apic.org: An outbreak is a sudden rise in the number of cases of a disease. An outbreak may occur in a community or geographical area or may affect several countries. It may last for a few days or weeks, or even for several years. Some outbreaks are expected each year, such as influenza.

Term	Definition
Personal Protective Equipment (PPE)	Equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses.
Pandemic	From CDC.gov: Pandemic refers to an epidemic that has spread over several countries or continents, usually affecting a large number of people. Epidemics occur when an agent and susceptible hosts are present in adequate numbers, and the agent can be effectively conveyed from a source to the susceptible hosts.
Patients Over Paperwork	CMS established an internal process to evaluate and streamline regulations with a goal to reduce unnecessary burden, to increase efficiencies, and to improve the beneficiary experience.
Post-acute care	Rehabilitation or palliative care services that beneficiaries receive after, or in some cases instead of, a stay in an acute care hospital. Depending on the intensity of care the person requires, treatment may include a stay in a facility (e.g., a SNF), ongoing outpatient therapy, or care provided at home. Medicare is a major payer.
Provider Relief Fund	<p>From HHS.gov: Provider Relief Fund payments are being disbursed via both "General" and "Targeted" Distributions. To be eligible for the General Distribution, a provider must have billed Medicare fee-for-service in 2019, be a known Medicaid and CHIP or dental provider and provide or provided after January 31, 2020 diagnoses, testing, or care for individuals with possible or actual cases of COVID-19, or prevented in the spread of SARS-CoV-2. HHS broadly views every person as a possible case of COVID-19.</p> <p>Targeted Distributions: HHS is allocating targeted distribution funding to providers in areas particularly impacted by the COVID-19 outbreak, rural providers, and providers requesting reimbursement for the treatment of uninsured Americans.</p>
Quality Assurance and Performance Improvement (QAPI) § 483.75	Each long-term care facility, including a facility that is part of a multi-unit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life.

Term	Definition
Quality Improvement Network (QIN)- Quality Improvement Organization (QIO)	From QIOProgram.org: The 12 regional Quality Innovation Network-Quality Improvement Organizations work with providers, community partners, beneficiaries and caregivers on data-driven quality improvement initiatives designed to improve the quality of care for people with specific health conditions.
Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2)	The most recent coronavirus known to transmit from animals to humans, first detected in China in December 2019, and causes a disease now referred to as “coronavirus disease 2019” (“COVID-19”)
Skilled nursing facility (SNF)	A facility that provides short-term recuperative and rehabilitative services (often referred to as post-acute care); Medicare is the dominant payer.
Social Security Act P.L. 74-271, approved August 14, 1935, 49 Stat. 620	From ssa.gov: Social Security provides replacement income for qualified retirees and their families. Social Security enrolls you in Original Medicare Part A (hospital insurance) and Part B (medical insurance). Individuals who are within three months of age 65 or older and not ready to start receiving monthly Social Security benefits can apply just for Medicare and wait to apply for retirement or spouses benefits.:
Strike Team	From training.fema.gov: A set number of resources of the same kind and type that have an established minimum number of personnel, common communications, and a designated leader.
Symptomatic Carrier	An individual who tests positive for COVID-19 and exhibits the known symptoms of the disease
Triage	The assignment of degrees of urgency to wounds or illnesses to decide the order of treatment of a large number of people or casualties.

Appendix B: Selection of Commission Members

This appendix summarizes the process MITRE used to select the members of the Commission.

Step 1: Nominations

MITRE launched a Commission website on May 14, announcing an open call for a cross-section of thought leaders from various stakeholder groups to serve on the Commission. Interested and qualified individuals were invited to nominate themselves or others to serve as Commission members by submitting a nomination form, responding to a series of questions, and uploading their resume or curriculum vitae prior to 5 p.m. EDT May 22. MITRE received more than 800 nominations.

The nomination form specified that desired membership would consist of a cross-section of thought leaders from stakeholder groups including, but not limited to, the following categories: academic researcher, clinician (various types), director and/or administrator of nursing home, electronic medical records expert, family member, industry professional, infection control and prevention expert, infectious disease expert, medical ethicist, nursing home resident, resident advocate, and state or local authority.

Step 2: Initial Review Process: Coding and Evaluating Nominations

MITRE composed a team of project members and subject matter experts to participate in the selection process (MITRE Review Team). The MITRE Review Team developed categories of pre-determined objective criteria applicable to the evaluation of potential Commission members from academia, industry, and administration. In addition, the MITRE Review Team established objective criteria applicable to the evaluation of potential nursing home resident/family member/resident advocates. Information from each application was reviewed and coded to ensure minimal applicant requirements were met.

The MITRE Review Team then used the appropriate unique category of objective criteria to conduct an initial evaluation of each applicant. In the instance where a nominee had expertise in more than one of the stakeholder categories, the MITRE Review Team considered the nominee under the most appropriate primary category based on the resume and the nominee's self-designated category assignment.

Step 3: Inter-Rater Reliability Analysis

When the initial review process was complete, the MITRE Review Team conducted an inter-rater reliability analysis to quantitatively assess consistency and replicability of the review process and to ensure the selection results met standards for acceptability.

Step 4: Secondary Review Process

Remaining candidates were distributed to reviewers from the MITRE Review Team based on nomination category and reviewer expertise. The MITRE Review Team considered a set of variables including scores, team notes, and observations to determine if each nominee was recommended for further consideration.

Step 5: Consensus-Seeking Discussion

A subset of the MITRE Review Team collaboratively considered the secondary reviewers' recommendations to achieve an initial list of potential candidates and a set of alternates. The result was shared for review and feedback with representatives from Atlas (an Alliance Partner), members of MITRE's senior leadership, and representatives of CMS.

Step 6: Announcement of Commission Members

MITRE invited selected nominees to serve on the Commission on June 12. Following acceptances, MITRE announced the 25 members of the Commission on June 19.

Appendix C: Findings and Evidence for Recommendations and Action Steps

Theme 3.1 – Testing and Screening

CMS and CDC have released iterative guidance recommending screening and testing of residents, staff and visitors. On July 22, CMS announced HHS would provide an additional \$5B from Provider Relief Fund, as well as 15,000 testing devices, to support testing and that CMS would begin requiring (rather than recommending) weekly staff testing in states with a 5% positivity rate or greater. Commission members stressed the importance of testing and screening and specifically noted challenges with funding and acquisition of testing and screening supplies. They further underscored the need for rapid and appropriate testing to mitigate the potential spread of SARS-CoV-2. The commission members recommended a targeted approach to ensure adequate supplies are available in one quarter, one half, and three quarters and all of the nation's nursing facilities by October 1, November 1, December 1, 2020, and January 1, 2021, respectively. Public input similarly supported the importance of testing and screening and urged additional funding to support a robust testing and screening regime. Effective screening and testing protocols and policies are critically necessary to reduce the risk of entry of SARS-CoV-2 within a facility and to control the virus's spread, particularly in the context of significant proportion of asymptomatic individuals.^{239, 240}

Screening, testing, and surveillance activities play a pivotal role in detecting and responding to infectious disease outbreaks. Without a viable vaccine, identifying and isolating people infected with SARS-CoV-2 is the only mechanism to prevent its spread.²⁴¹ Diagnostic testing is used to identify infected individuals based on the ability to detect the presence of the genetic signature of the SARS-CoV-2 virus in respiratory secretions. Testing of symptomatic individuals rapidly is critical to subsequent isolation of those individuals away from susceptible and vulnerable residents and staff, as well as the need to provide immediate medical care to those individuals if necessary. Furthermore, targeted testing of staff and residents to capture asymptomatic or pre-symptomatic individuals would enhance the ability of nursing homes to prevent or control the spread of infection. Key to effective testing strategies is accuracy of tests, availability of tests, and rapid turnaround times to receive and report results.

Screening attempts to prevent individuals with a recent positive test result, SARS-CoV-2 like symptoms, or recent exposure risk from entering into a nursing home or interacting with staff and residents. As more information is learned about the disease presentation, screening protocols should be adapted to capture the common symptoms of infected individuals. However, while screening can be an effective way to limit exposures within a nursing home, the substantial percentage of individuals that remain asymptomatic after exposure means that nursing homes cannot rely on screening alone to prevent and mitigate the spread of SARS-CoV-2 within their facilities.

Theme 3.2 – Equipment and PPE

Following the initial announcement of the COVID-19 pandemic outbreak, CMS has issued guidance on the use of PPE March 10 and April 2. This guidance included updated CDC recommendations for essential care workers to address PPE use when working with known or suspected COVID-19 residents. PPE is “specialized clothing or equipment, worn by an employee for protection against hazard.”²⁴² PPE has been demonstrated to be critically important in protecting staff from the spread of SARS-CoV-2 and in turn, the residents whom they support. OSHA released guidance that supports CDC recommendations for adequate supply and use of PPE to protect nursing home workers.²⁴³ PPE use, along with a combination of other infectious disease mitigation strategies, have been shown to reduce spread of illness.²⁴⁴ Along with this guidance, CMS collaborated with the CDC in the development and release of National COVID-19 training modules to provide guidance to nursing home staff. These training modules covered important infection control and PPE information vital to the successful containment or reduction of SARS-CoV-2 within nursing homes. This release of these modules on March 11 was at the beginning of this pandemic.

As concerns and cases of the virus grew, the supplies of PPE diminished. Many nursing homes across the country were tasked with finding and securing PPE on their own during this crisis. Most facilities had trouble securing quality PPE for staff and residents which resulted in increased cases of people who tested COVID-19 positive within a nursing home. In response to the national PPE shortage, FEMA issued 14-day supply of PPE to all nursing homes. There was widespread press coverage of the inadequacy of supply in terms of volume and quality.²⁴⁵

Commission members have been adamant about CMS responsibility to ensure that every nursing home in the country has an adequate supply of high-quality PPE. Commission members requested federally funded PPE for equal allocation while having the ability to reallocate when surges occur. The Commission further emphasized the importance of the supplies being appropriately fitted and the staff being properly trained on use.²⁴⁶ The public input on this topic primarily focused on the need to provide direct priority access of adequate PPE supply to nursing home facilities for staff and visitors. The public also mentioned the importance of local, statewide and regionally tracking of PPE to prepare for a future surge.

Theme 3.5 – Communication

Pursuant to the CMS final rule *Reform of Requirements for Long-Term Care Facilities* at 81 FR 68688 in 2016,²⁴⁷ CMS imposes minimum standards on nursing homes that ensure timely and adequate advance notice for family and caregivers on resident status at least 30 days prior to such critical care transitions as transfer (whether to another part of the facility or another facility such as a hospital) and discharge. If immediate transfer is required or the individual’s safety is in jeopardy, nursing homes are required to notify the resident and caregivers as soon as practicable *before* transfer or discharge. Nursing homes are also required to have written policies and procedures on resident visitation rights, including any clinically necessary or reasonable restriction or safety limitations the nursing home may place on such rights.²⁴⁸ However, many of these provisions did not prescribe a manner, timeframe, or frequency for which communication about these events is to occur in the event of an ongoing state or nationwide public health emergency, or specify acceptable alternatives or adaptive methods of communication when a

nursing home has to operate under such restrictions and make decisions rapidly pursuant to state and federal guidelines on cohorting and restrictions on visitation. It is unlikely, for example, that nursing homes would also be able to ensure the written policies and procedures on visitation rights are updated frequently enough to reflect such restrictions, but there is currently no nationwide CMS-endorsed standards for an alternative. It is also unclear whether CMS would allow flexibilities for notice after the fact. To date, CMS has provided the following relief or guidelines to nursing homes on communications with residents and caregivers during the COVID-19 pandemic:

- **March 4, 2020 Suspension of Survey Activities:** CMS limited survey activity to immediate jeopardy complaints (likely to result in harm) and some other special circumstances only.²⁴⁹
- **March 13, 2020 Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes:** CMS stated that 1) facilities should maintain a person-centered approach to...communicating effectively with residents, resident representatives and/or their family, and understanding their individual needs and goals of care; and 2) facilities should communicate through multiple means to inform individuals and nonessential healthcare personnel of the visitation restrictions, such as through signage at entrances/exits, letters, emails, phone calls, and recorded messages for receiving calls²⁵⁰
- **Updated July 2020 Toolkit on State Actions to Mitigate COVID-19 Prevalence in Nursing Homes:**²⁵¹ CMS included a disclaimer that this information did not constitute agency guidance, but provided these Nursing Home Communications examples from states. A few examples of state innovations are as follows:
 - **Arizona:** Nursing homes are leveraging social media to increase morale, optimism, and to reassure its community about loved ones in the nursing home.
 - **Delaware:** Nursing home facilitates one-on-one electronic communication with facility ombudsman to ensure families are connected to staff on important information. Nursing home placed large signs with room numbers on long-term care facility windows so families could easily identify their loved ones.
 - **Indiana:** State Department of Health released communication guidelines for long-term care facilities and set up outreach emails for communicating with concerned loved ones. State also issued guidance for designating essential family caregivers to participate more in care.
 - **Pennsylvania:** Due to concerns that family and friends emergency may struggle with changes in protocol, rights, and policies during COVID-19, state set up the Pennsylvania Long-Term Care Ombudsman Program to help with a new statewide resource called Virtual Family Council, offering weekly online meetings with a local ombudsman and a team of 10 local experts. The weekly online meetings participants

can ask questions, share concerns, or listen to learn and gather information and receive updates to resources and policies will be provided as well.

One recent opinion echoed the need for effective communication with families of nursing home residents during the pandemic after state and CMS restrictions, stating that “Because information about the outbreak is evolving rapidly, often on a daily basis, facilities should be prepared to update their messaging quickly to ensure residents and family members have the most current information they need to stay safe and healthy.” The opinion issued the following recommendations on communication from providers on their challenges with communicating with families of long-term care residents, stating that communication with families must: 1) provide a clear purpose for calling; 2) express empathy for emotions of family members and loved ones; 3) specify the nursing home’s protocols for helping families stay educated; 4) reassure recipient that care of their loved one is the highest priority; and 5) instill a message of togetherness and cooperation.²⁵² Communication guidelines from Indiana cited earlier also agree that it is critical to calm concerns when communicating with family representatives and suggested methods such as establishing a facility listserv or chat room where staff members provide a daily “briefing” to residents, designated representatives, and other family members about what is happening in the facility, and any updated to the facility's restricted visitation policy and how the facility will be implementing it.²⁵³ Given the varied approaches across these several states, CMS’ recently issued statements about the nursing home’s responsibility to communicate care-planning with residents and families in a person-centered manner may benefit from additional detail and guidance to maintain consistency and effectiveness for the long-term across states and clarify how nursing homes might still meet requirements for participation if normal survey activities resume, but restrictions are still in effect in their state.

Theme 3.6 – Workforce Ecosystem: Stopgaps for Resident Safety

Surge Support: The CDC also developed guidelines for healthcare facilities to address potential staffing shortfalls “*Strategies to Mitigate Healthcare Personnel Staffing Shortages.*”²⁵⁴ CDC highlights that as the pandemic progresses, staffing shortages will increase due to direct-care worker exposures, illness, or need to care for family members at home. As maintaining appropriate staffing levels is essential to providing a safe working environment and proper resident care, the CDC guidance offers both contingency capacity strategies and crisis capacity strategies for nursing homes that experience staffing shortages. Once a facility identifies its minimum staffing needs, the CDC recommends the facility reach out to local, state, and federal public health partners for assistance in identifying additional direct care workers who are available for hire. For healthcare facilities with existing staffing shortages, the CDC recommends developing regional strategies to send residents to alternate healthcare facilities/ care sites.

Multi-employer Direct Care Providers: Studies indicate an increased risk of COVID-19 infection of staff working across different nursing facilities.²⁵⁵ Additionally, a preliminary analysis from the CDC concluded that the sharing of staff members among multiple nursing homes — along with employees continuing to work while sick — helped to hasten the spread of SARS-CoV-2 in Washington state and other states.²⁵⁶ Working in multiple facilities, however, is the economic reality for many nursing home staff.²⁵⁷

24/7 RN Coverage: While staffing in long-term care facilities has been a chronic issue, there is little consideration for acuity when developing staffing patterns on a daily basis. Given the high acuity and labile nature of COVID-19 positive residents' status, RN oversight is recommended around the clock when the resident population experiences a COVID-19 positive test. RNs assess and manage all resident populations with appropriate interventions, admit and discharge residents, and develop plans of care and wellness for all residents in the facility. The rapid intervention of an RN may reduce unnecessary hospitalizations.

In 2014, the Coalition of Geriatric Nursing Organizations (CGNO) recommended that an RN be present in nursing homes at all times for oversight of resident care, resident assessment, supervision of licensed nursing staff and delegation to certified nursing assistants. This position statement was endorsed by the ANA.²⁵⁸

Infection Preventionists and Infection Prevention Educators: Deficiencies in infection prevention and control in nursing homes were prevalent prior to the COVID-19 pandemic.²⁵⁹ As COVID-19 cases and deaths in nursing homes increased, CMS issued an informational bulletin in February 2020 advising healthcare facilities to review the Centers for Disease Control (CDC) COVID-19 advisory and recommendations as well as their own infection control policies.²⁶⁰ In April 2020, CMS issued guidance directing facilities to screen staff, residents, and visitors for symptoms, ensure staff use PPE "to the extent available," and designate separate staff and facilities or units for COVID-19 cases.²⁶¹ In May 2020, CMS issued an informational toolkit with best practices for states to mitigate COVID-19 in nursing homes.²⁶²

WHO says: "Infection prevention and control (IPC) is a scientific approach and practical solution designed to prevent harm caused by infection to patients and health workers. It is grounded in infectious diseases, epidemiology, social science and health system strengthening. IPC occupies a unique position in the field of patient safety and quality universal health coverage since it is relevant to health workers and patients at every single health-care encounter. No country, no health-care facility, even within the most advanced and sophisticated health-care systems, can claim to be free of the problem of healthcare-associated infections. The need for having IPC programs nationally and at the facility level is clearly reinforced within the WHO 100 Core Health Indicators list."²⁶³

Theme 3.7 – [Workforce Ecosystem: Strategic Reinforcement](#)

CNA On-the-job Training and Recruitment: Direct care worker positions are often viewed as low-wage, entry-level jobs with little to no opportunity for advancement and thus workers choose or move on to other professions. High turnover and workforce shortages have an impact on care quality.²⁶⁴ The pandemic has exacerbated staffing challenges because of the increased resident acuity and risks of providing direct care residents with COVID-19.

To assist in addressing potential nursing home staffing shortages during the COVID-19 pandemic and to reduce barriers for SNFs and NFs to hire staff, CMS provided two waivers related to workforce staffing as part of its long-term care blanket waivers.²⁶⁵ First, CMS waived the requirement at 42 CFR 483.35(d) that a facility may not employ anyone for longer than four months unless they meet certain training and certification requirements, provided nursing homes utilize competency assessments to ensure that these nurse aides are competent to provide

relevant nursing and nursing-related services. While the waiver provides flexibility at the federal level, state occupational licensing and state regulatory agencies must approve the waiver for this temporary hiring of nursing assistants, and only certain states have done so. AHCA/NCAL developed an 8-hour, free, online “Temporary Nurse Aide”²⁶⁶ training course to provide a pathway for providers to utilize the waiver once they received state regulatory approval. Second, CMS modified the nurse aide training requirements at 42 CFR 483.95(g)(1) by postponing the deadline for nursing assistants to receive at least 12 hours of in-service training annually throughout the COVID-19 PHE until the end of the first full quarter after the declaration of the PHE concludes.

CNAs spend more time than any other nursing staff assisting residents, providing a median of 2.1 hours of hands-on care per resident per day.²⁶⁷ Wages for nursing assistants have not kept up with inflation over the past 10 years, and there is a high rate of poverty among CNAs.²⁶⁸ In the wake of the pandemic, CNA education has been interrupted. Private CNA schools are closed, and it is not possible to conduct the necessary hands-on training of CNAs. Moreover, the stigma associated with being a CNA and competition from other industries that employ workers with similar education and experience (e.g., service workers, warehouse fulfillment) makes it difficult to fill these positions. CNA shortages is a serious, complex problem.

Longstanding Issues: Chronic long-term care workforce challenges were documented in the 2013 Long Term Care Commission report to Congress (LTCCR) and continues today due to: low levels of compensation; lack of benefits; limited opportunities for professional advancement (e.g., no clinical ladder, no assistance in progressing into LPN/RN training); and high resident-to-staff ratios.

Federal law has few requirements for nurse staffing in long-term care facilities and haven’t been updated since the Nursing Home Reform Act was implemented in 1987.²⁶⁹ A 2019 poll²⁷⁰ of nurse-to resident ratios of long-term care and SNF nurses in a private Facebook group found unsafe nurse-resident staffing ratios pre-dated the COVID-19 pandemic:

- 32:1 nurse and 16:1 CNA- Ohio
- 44:1 nurse and 44:2 CNA- Tennessee
- 50:2 nurse and 15:3 CNA- New York
- 66:2 nurse and 66:4 CNA- Illinois
- 50:1 nurse and 30:1 CNA- Georgia
- 60:1 nurse and 60:3-4 CNA- Nebraska

Theme 3.8 – Technical Assistance and Quality Improvement

Nursing homes with COVID-19 outbreaks are receiving on-site technical assistance and education from QIN-QIOs^{271, 272, 273} and Federal Task Force Strike Teams.²⁷⁴ Other training is available online: weekly infection control webinars for nursing homes through the QIO program,²⁷⁵ COVID-19 Prevention in Long-term Care Facilities,²⁷⁶ Nursing Home Infection Preventionist Training Course,²⁷⁷ and Infection Preventionist Specialized Training - IPCO

Version 2.²⁷⁸ Several commission members recommended leveraging QIOs to provide on-site training and assistance to nursing homes, specifically nursing homes in COVID-19 “hot spots,” to improve resident care and residents’ healthcare outcomes.²⁷⁹ One commission member recommended increasing the number of QIOs, which would enable all QIOs to serve a smaller segment of the country and, thus, fewer nursing homes, giving QIOs the ability to provide more assistance. In addition to providing on-site training, the Commission recommended creating COVID-19 QAPI tools for nursing homes.

Theme 3.10 – [Nursing Home Data](#)

Principal Recommendation 10A:

CMS and federal partners have initiated actions on some of these issues. During the July 21, 2020 Commission meeting, CMS and CDC representatives described how they are working together to refine and create more specificity for certain COVID-19 NHSN data elements. Based on nursing home data reported to CDC, CMS and federal partners have provided staff for Task Force Strike Teams to provide technical assistance and training to select nursing homes with increased COVID-19 cases. CMS announced that they will also use the data to provide states with a list of nursing homes with increased cases each week as part of the weekly Governor’s report to assist states with targeting support to high-risk nursing homes.²⁸⁰ Commission members and public comments supported a continued focus on obtaining data from nursing homes that can be acted upon in a meaningful way while considering the associated costs of data collection.

Principal Recommendation 10B:

When CMS initiated a joint effort with CDC to collect COVID-19 data from nursing homes nationwide, it was announced that CDC would be providing a reporting tool to collect the data and that there were plans to make the data publicly available.²⁸¹ CMS subsequently established the [COVID-19 Nursing Home Data website](#), which provides access to the COVID-19 Public File containing data reported by nursing homes to CDC’s NHSN system, along with related resources and statistics.²⁸² During the July 29 Commission meeting, CMS also indicated that work on a new consolidated source of relevant guidance and regulations had been initiated. Commission members and public comments were generally quite supportive of continued efforts to develop a central location for nursing homes to submit COVID-19 data and to find essential information from CMS and partners.

Principal Recommendation 10C:

CMS has released guidance requiring facilities to report to the CDC communicable diseases, healthcare-associated infections, and potential outbreaks in a standardized format and frequency defined by CMS and CDC. According to requirements at 42 CFR 483.80 and CDC guidance, nursing homes must notify state or local health department about residents or staff with suspected or confirmed COVID-19, residents with severe respiratory infection resulting in hospitalization or death, or ≥ 3 residents or staff with new-onset respiratory symptoms within 72 hours of each other.^{283, 284} CMS also requires nursing homes to report COVID-19 facility data to the CDC, residents, their representatives and families of residents in facilities and updated the COVID-19 Focused Survey for Nursing Homes, Entrance Conference Worksheet, COVID-19

Focused Survey Protocol, and Summary of the COVID-19 Focused Survey for Nursing Homes to reflect COVID-19 reporting requirements.²⁸⁵

²³⁹ Gao, Z., Xu, Y., Sun, C., Wang, X., Guo, Y., Qiu, S., & Ma, K. (2020). A systematic review of asymptomatic infections with COVID-19 [Advance online publication]. *Journal of Microbiology, Immunology, and Infection*. <https://doi.org/10.1016/j.jmii.2020.05.001>

²⁴⁰ Kimball, A., Hatfield, K. M., Arons, M., James, A., Taylor, J., Spicer, K., & Bell, J. M. (2020, March 20). Asymptomatic and presymptomatic SARS-CoV-2 infections in residents of a long-term care skilled nursing facility—King County, Washington. *Morbidity and Mortality Weekly Report*, 69(13), 377. <http://dx.doi.org/10.15585/mmwr.mm6913e1>

²⁴¹ Cheng M. P., Papenburg, J., Desjardins, M., Kanjilal, S., Quach, C., Libman, M., Dittrich, S., & Yansouni, C. P. (2020). Diagnostic testing for severe acute respiratory syndrome-related Coronavirus 2: A narrative review. *Ann Intern Med*, 172(11), 726-734. <https://www.acpjournals.org/doi/10.7326/M20-1301>

²⁴² Bloodborne pathogen. 29 CFR 1910.1030(b). <https://www.law.cornell.edu/cfr/text/29/1910.1030>

²⁴³ Occupational Safety and Health Administration. (n.d.). *COVID-19 Guidance for Nursing Home and Long-Term Care Facility Workers*. <https://www.osha.gov/Publications/OSHA4025.pdf>

²⁴⁴ Chou, R., Dana, T., Buckley, D. I., Selph, S., Fu, R., & Totten, A. M.. (2020). Epidemiology of and risk factors for coronavirus infection in health workers. *Annals of Internal Medicine*, 173(2), 120-136. <https://www.acpjournals.org/doi/10.7326/M20-1632>

²⁴⁵ Rau, J. (2020, June 11). *Nursing homes run short of COVID-19 protective gear as federal response falters*. NPR. <https://www.npr.org/sections/health-shots/2020/06/11/875335588/nursing-homes-run-short-of-covid-19-protective-gear-as-federal-response-falters>

²⁴⁶ Kimball, A., Hatfield, K. M., Arons, M., James, A., Taylor, J., Spicer, K., Bardossy, A. C., Oakley, L.P., Tanwar, S., Chisty, Z., Bell, J. M., Methner, M., Harney, J., Jacobs, J.R., Carlson, C. M., McLaughlin, H.P., Stone, N., Clark, S., Bronstrom-Smith, C., (2020, April 3). Asymptomatic and presymptomatic SARS-CoV-2 infections in residents of a long-term care skilled nursing facility — King County, Washington, March 2020. *Morbidity and Mortality Weekly Report*, 69(13), 377-381. https://www.cdc.gov/mmwr/volumes/69/wr/mm6913e1.htm?s_cid=mm6913e1_w

²⁴⁷ Medicare and Medicaid Programs. (2016, October 4). *Reform of Requirements for Long-Term Care Facilities*. 81 Fed. Reg. 68688 (2016). <https://www.govinfo.gov/content/pkg/FR-2016-10-04/pdf/2016-23503.pdf>

²⁴⁸ *Id.*

²⁴⁹ Centers for Medicare & Medicaid Services Center for Clinical Standards and Quality/Quality, Safety & Oversight Group. (2020, March 4). *Memorandum to State Survey Agency Directors: Suspension of Survey Activities*. <https://www.cms.gov/files/document/gso-20-12-all.pdf>

²⁵⁰ Centers for Medicare & Medicaid Services Center for Clinical Standards and Quality/Quality, Safety & Oversight Group. (2020, March 13). *Memorandum to State Survey Agency Directors: Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes (REVISED)*. <https://www.cms.gov/files/document/gso-20-14-nh-revised.pdf>

²⁵¹ Centers for Medicare & Medicaid Services. (2020, August). *Toolkit on State Actions to Mitigate COVID-19 Prevalence in Nursing Homes*. <https://www.cms.gov/files/document/covid-toolkit-states-mitigate-covid-19-nursing-homes.pdf>

²⁵² *Id.*

²⁵³ Indiana State Department of Health. (2020, May 5). *Long-term Care Facility Communication Guidelines: Informing Family Members during COVID-19*. https://www.coronavirus.in.gov/files/IN_COVID-19_comm%20guidelines%205.3.20.pdf

²⁵⁴ Centers for Disease Control and Prevention (2019, July 17) *Strategies to Mitigate Healthcare Personnel Staffing Shortages* <https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html>

²⁵⁵ SARS-CoV-2 positivity was 4-fold higher in staff working across different care homes. Ladhani, S. N. et al. London Care Home Investigation Team (2020). Increased risk of SARS-CoV-2 infection in staff working across different care homes enhanced CoVID-19 outbreak investigations in London care Homes. *The Journal of infection*, S0163-4453(20)30508-9. Advance online publication. <https://doi.org/10.1016/j.jinf.2020.07.027>

²⁵⁶ McMichael, T. M. et al. (2020, March 18). COVID-19 in a Long-Term Care Facility — King County, Washington, February 27–March 9, 2020. *MMWR Morb Mortal Wkly Rep* 2020;69:339-342.

<https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e1.htm>

²⁵⁷ Reported by Commission members; “Some certified nursing assistants need to work jobs at more than one home to earn enough to support their families.” Romero, L., Mosk, M., Freger, H., & Pecorin, A. (2020, May 5) *With millions out of work, nursing homes under siege from coronavirus plead for more staff.*

<https://abcnews.go.com/Health/millions-work-nursing-homes-siege-coronavirus-plead-staff/story?id=70513441>

²⁵⁸ Nursing World. (2014, November 12). *ANA Nursing Staffing Requirements to Meet the Demands of Today's Long Term Care Consumer.* <https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/id/nursing-staffing-requirements-to-meet-the-demands-of-todays-long-term-care-consumer/>

²⁵⁹ U.S. Government Accountability Office. (2020, May 20) *Infection Control Deficiencies Were Widespread and Persistent in Nursing Homes Prior to COVID-19 Pandemic.* <https://www.gao.gov/assets/710/707069.pdf>

²⁶⁰ Centers for Medicare & Medicaid Services. (2020, February 6). *Information for Healthcare Facilities Concerning 2019 Novel Coronavirus Illness (2019-nCoV).* <https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and-memos-states-and/information-healthcare-facilities-concerning-2019-novel-coronavirus-illness-2019-ncov>

²⁶¹ Centers for Medicare & Medicaid Services. (2020, April 2). *COVID-19 Long-Term Care Facility Guidance.*

<https://www.cms.gov/files/document/4220-covid-19-long-term-care-facility-guidance.pdf> ;

²⁶² Centers for Medicare and Medicaid Services. (2020, May 13). *Toolkit on State Actions to Mitigate COVID-19 Prevalence in Nursing Homes.* <https://www.cms.gov/files/document/covid-toolkit-states-mitigate-covid-19-nursing-homes.pdf>

²⁶³ World Health Organization. (2020). *Infection Prevention and Control.* <https://www.who.int/infection-prevention/about/ipc/en/>

²⁶⁴ Quality Improvement Organizations. (2019 June). *Resources to Support Staff Stability in Post-Acute and Long-Term Care Settings.*

[https://qioprogram.org/sites/default/files/editors/141/Resources To Support Staff Stability 20190626 508.pdf](https://qioprogram.org/sites/default/files/editors/141/Resources%20To%20Support%20Staff%20Stability%2020190626%20508.pdf)

²⁶⁵ Centers for Medicare & Medicaid Services. (2020, March 6). *COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers.* <https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf>

²⁶⁶ American Healthcare Association Education. (2020). *Temporary Nurse Aide Course.*

<https://educate.ahcancal.org/products/temporary-nurse-aide>. As of 8/11, nine states (Delaware, Indiana, Iowa, Maryland, Nebraska, New Jersey, New York, Texas, and West Virginia) have permitted facilities to use the AHCA/NCAL temporary training, and 13 states (Alabama, Connecticut, District of Columbia, Georgia, Illinois, Kansas, Mississippi, North Carolina, New Hampshire, Pennsylvania, South Carolina, Tennessee, and Virginia) have included the AHCA/NCAL training as part of a broader set of requirements for temporary CNAs.

²⁶⁷ PHI (2019, September 3). *U.S. Nursing Assistants Employed in Nursing Homes.* <https://phinational.org/resource/u-s-nursing-assistants-employed-in-nursing-homes-key-facts-2019/> RNs provide .4 staff hours per resident per day, and LPNs provide .8 staff hours per resident per day.

²⁶⁸ CNAs working in nursing homes earn a median income of \$22,200 per year. Low annual earnings result in a relatively high rate of poverty among nursing assistants: 13 percent live below the federal poverty line.

²⁶⁹ Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, Subtitle C: Nursing Home Reform (1987). The Nursing Home Reform Law of 1987 (passed as part of the Omnibus Budget Reconciliation Act) requires these facilities to have:

- A registered nurse eight consecutive hours, seven days a week
- Licensed nurses 24 hours a day re
- Otherwise “sufficient” nursing staff to meet residents’ needs

See 42 USC 1395i-3(b)(4)(C)(i)

²⁷⁰ Wofford, P. (2019, July 11). *Nurses Say Staffing Ratios In Long Term Care Facilities Are Unsafe.* Nurse.org. <https://nurse.org/articles/nurse-staffing-unsafe-long-care-facilities/>

²⁷¹ Centers for Medicare & Medicaid Services. Quality Improvement Organizations. (2020, July 13). *CMS Directs Additional Resources to Nursing Homes in COVID-19 Hotspot Areas.* <https://qi.ipro.org/2020/07/13/cms-directs-additional-resources-to-nursing-homes-in-covid-19-hotspot-areas/>

²⁷² In FY 2019, CMS proposed to revise 42 CFR § 483. 75 to permit facilities to more flexibly design their QAPI programs to meet their facility needs. Medicare and Medicaid Programs; Requirements for Long-Term Care Facilities: Regulatory Provisions To Promote Efficiency, and Transparency (85 FR 34737, 34738) available at <https://www.govinfo.gov/content/pkg/FR-2019-07-18/pdf/2019-14946.pdf> (page 34738).

²⁷³ In June 2020, CMS announced new state requirements to perform on-site surveys at nursing homes that have experienced COVID-19 outbreaks or cases and starting in FY 2021 perform annual infection control surveys of 20 percent of nursing homes. The guidance also authorizes expanded survey activities related to additional aspects of care once a facility enters Phase 3 (e.g., complaint investigations that do not involve immediate jeopardy); <https://www.cms.gov/files/document/qso-20-31-all.pdf>

²⁷⁴ Centers for Medicare & Medicaid Services. (2020, July 22). *Trump Administration Announces New Resources to Protect Nursing Home Residents Against COVID-19*. <https://www.cms.gov/newsroom/press-releases/trump-administration-announces-new-resources-protect-nursing-home-residents-against-covid-19>

²⁷⁵ Centers for Medicare & Medicaid Services. Quality Improvement Organizations. (2020, August 13). *National CMS/CDC Nursing Home COVID-19 Training*. <https://qioprogram.org/nursing-home-trainings>

²⁷⁶ Center for Disease Control and Prevention. Healthcare Workers. Training for Healthcare Professionals. (2020, July 20). *COVID-19 Prevention in Long-term Care Facilities*. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/training.html>

²⁷⁷ Center for Disease Control and Prevention. Healthcare Workers. Training for Healthcare Professionals. (2020, July 20). *Nursing Home Infection Preventionist Training Course*. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/training.html>

²⁷⁸ ahcancaLED. (n.d.) *Infection Preventionist Specialized Training - IPCO Version 2*. <https://educate.ahcanca.org/p/ipcov2>

²⁷⁹ Coronavirus Commission for Safety and Quality in Nursing Homes. (2020, July 7).

²⁸⁰ Centers for Medicare & Medicaid Services. (2020, July 22). *Trump Administration Announces New Resources to Protect Nursing Home Residents Against COVID-19 [Press release]*. <https://www.cms.gov/newsroom/press-releases/trump-administration-announces-new-resources-protect-nursing-home-residents-against-covid-19>

²⁸¹ Center for Medicare & Medicaid Services. (2020, April 19). *Trump Administration Announces New Nursing Homes COVID-19 Transparency Effort [Press release]*. <https://www.cms.gov/newsroom/press-releases/trump-administration-announces-new-nursing-homes-covid-19-transparency-effort>

²⁸² Centers for Medicare & Medicaid Services. (2020, August 16). *COVID-19 Nursing Home Data*. <https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg/>

²⁸³ Wright, D. R. (2020, March 13). *Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes (REVISED)*. Department of Health & Human Services. Centers for Medicare & Medicaid Services. <https://www.cms.gov/files/document/3-13-2020-nursing-home-guidance-covid-19.pdf>

²⁸⁴ Wright, D. R. (2020, April 19). *Upcoming Requirements for Notification of Confirmed COVID-19 (or COVID-19 Persons under Investigation) Among Residents and Staff in Nursing Homes*. Department of Health & Human Services. Centers for Medicare & Medicaid Services. <https://www.cms.gov/files/document/qso-20-26-nh.pdf>

²⁸⁵ Wright, D. R. (2020, May 6). *Interim Final Rule Updating Requirements for Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff in Nursing Homes*. Department of Health & Human Services. Centers for Medicare & Medicaid Services.

Appendix D: List of CMS Actions to Date

This list captures the actions that CMS has taken through August 6, 2020, to respond to the COVID-19 pandemic in the United States.

- (1) [Initial Action to Prepare Healthcare Facilities](#) (February 6, 2020)
- (2) [Screening of entrants into nursing homes](#) (March 4, 2020)
- (3) [The use of PPE](#) (March 10, 2020)
- (4) [Restriction of staff and visitors](#) (March 13, 2020)
- (5) [Inspections and immediate jeopardy](#) (March 23, 2020)
- (6) [COVID-19 Survey for Nursing Homes Webinar Series](#) (March 23, 2020)
- (7) [Hospitals/laboratories can test for COVID-19](#) (March 30, 2020)
- (8) [Infection control responsibilities](#) (April 2, 2020)
- (8a) [Emergency Declaration Blanket Waivers](#) (April 9, 2020) (same as 23)
- (9) [Payment for COVID-19 testing doubles](#) (April 15, 2020)
- (10) [Nursing homes must report cases to residents/families](#) (April 19, 2020)
- (11) [Notification of Confirmed COVID-19 ... Residents/Staff](#) (April 19, 2020)
- (12) [Independent COVID-19 Commission](#) (April 30, 2020)
- (13) [Details to State Survey Agency directors](#) (May 6, 2020)
- (14) [COVID-19 toolkit for Nursing Homes](#) (May 13, 2020)
- (15) [Guidance on the reopening of nursing homes](#) and [related FAQs](#) (May 18, 2020)
- (16) [COVID-19 survey activities](#) (June 1, 2020)
- (17) [COVID-19 nursing home results from inspections](#) (June 4, 2020)
- (18) [Coronavirus Commission membership](#) (June 19, 2020)
- (19) [FAQs on nursing home visitation](#) (June 23, 2020)
- (20) [The end of the emergency blanket waiver](#) (June 25, 2020)
- (21) [Assistance from QIOs to hotspot nursing homes](#) (July 10, 2020)

- (22) [Rapid point-of-care diagnostic devices and tests](#) (July 14, 2020)
- (23) [New resources to protect nursing home residents](#) (July 22, 2020)
- (23a) [Emergency Declaration Blanket Waivers](#) (July 28, 2020)
- (24) [Reimbursement for counseling isolated residents](#) (July 30, 2020)
- (25) [CMS Flexibilities to Fight COVID-19](#) (July 30, 2020)
- (26) [COVID-19 Nursing Home Data](#) (Aug. 2, 2020)
- (27) [Nursing Home Data - Point of Care Device Allocation](#) (Aug. 6, 2020)

Appendix E: Public Input Summary

1. Background

On behalf of the Coronavirus Commission for Safety and Quality in Nursing Homes (the Commission), MITRE sought public input to align with the four Commission objectives and to allow the public to formally note their support of nursing home residents and staff.

2. Purpose

Public feedback was sought as input for the Commission's development of actionable recommendations to CMS to evaluate and improve the ongoing novel Coronavirus (COVID-19) response and support of nursing homes. Public input comments and resources were categorized against the four Commission objectives:

- **Objective 1:** Identify best practices for facilities to enable rapid and effective identification and mitigation of transmission of COVID-19 and other infectious diseases in nursing homes.
- **Objective 2:** Recommend best practices as exemplars of rigorous infection control practices and facility resiliency that can serve as a framework for enhanced oversight and quality monitoring activities.
- **Objective 3:** Endeavor to identify best practices for improved care delivery and responsiveness to the needs of all nursing home residents in preparation for, during, and following an emergency.
- **Objective 4:** Leverage new sources of data to improve existing infection control policies and enable coordination across federal surveyors, contractors, and state and local entities to mitigate coronavirus infection and future emergencies.

Commission members had the opportunity to review public inputs categorized by objectives and further into discussion themes during the second half of their convening schedule. Public input was used to drive the identification of additional relevant, actionable interventions for CMS to improve quality and safety in nursing homes.

3. Scope and Approach

Public input was received from a multitude of nursing home stakeholders: nursing home staff and residents, essential care partners, family, friends, members of the long-term care industry, and additional stakeholders or affiliated organizations. Minimal public input was received through a public-facing email address; robust public input was received via a website-based feedback form. MITRE published a [press release](#) to promote the website-based feedback form option, noting the Commission's objectives and intention to review and incorporate public feedback into their recommendations.

The public input form was made live via the Commission website on July 6. MITRE formally published the website-based public input press release on July 10, and accepted inputs via the website-based form through July 18.

Through the public input form, individuals and organizations had the opportunity to: express their interest in the well-being of nursing home residents without providing additional comment; express their interest in the well-being of nursing home staff without providing additional comment; submit a 500-character open-ended comment providing their perspective as it aligned to one of the four (4) Commission objectives; and/or provide an attachment up to five pages long (e.g., formal letters, publications, or other resources).

In total, the Commission received 632 responses via the website-based feedback form.

- 214 entries focused on the well-being of nursing home residents without further comment
- 29 entries focused on the well-being of nursing home staff without further comment
- 301 open-response entries addressed at least one Commission objective
- 87 entries included an attachment
- 1 empty open-response entry

These open-ended comments and attachments were assigned to one of the four (4) Commission objectives; then, they were further categorized into (1) established themes derived from Commission discussions during the first half of their convening schedule, (2) emerging Commission discussion themes, and (3) new themes that emerged from the public input content. The full list of themes includes: Testing/Screening, Equipment/Supplies/Personal Protective Equipment (PPE), Cohorting, Social/Emotional Health, Essential Care Partner Support, Communications, Workforce, Shared Accountability for Quality Management and Improvement, Reporting, Survey/Assessment, Quality Control Policies and Practices, General Policy Guidance and/or Requirements, Nursing Home Policies and Practices, Funding, and Other.

A summary of the public input was provided to Commission members. Commission members had the opportunity to utilize the summary to refine their recommendations and action steps associated with each recommendation. Specifically, public input commonly highlighted the need for urgent coordinated action to support the continued operations of nursing homes. Many comments also called for enhanced operational and support practices to create a more robust environment of care that prioritizes resident, essential care partner, and staff quality of life and safety. These comments largely aligned with and augmented the recommendations of the Commission. This alignment is made clear in the tables that follow.

4. Alignment with Commission Objectives and Themes

The Commission received 301 open-ended comments from the public through the website-based form. Each comment was first assigned to one of the four (4) Commission objectives to which it primarily applied. These assignments displayed a primary focus on policy and process recommendations in direct support of the health and well-being of nursing home residents, essential care partners, and the nursing home workforce.

Table 1: Number of Open-Ended Comments on Each Commission Objective

Commission Objective	Count of Open-Ended Comments
Objective 1: Identify best practices for facilities to enable rapid and effective identification and mitigation of transmission of COVID-19 and other infectious diseases in nursing homes.	39
Objective 2: Recommend best practices as exemplars of rigorous infection control practices and facility resiliency that can serve as a framework for enhanced oversight and quality monitoring activities.	71
Objective 3: Endeavor to identify best practices for improved care delivery and responsiveness to the needs of all nursing home residents in preparation for, during, and following an emergency.	185
Objective 4: Leverage new sources of data to improve existing infection control policies and enable coordination across federal surveyors, contractors, and state and local entities to mitigate coronavirus infection and future emergencies.	6

Open-ended responses were then organized by theme. Comments were coded to multiple themes, as appropriate. These assignments more specifically showed the public’s focus on social and emotional health needs, workforce concerns, and essential care partner support. The following table is a count of open-ended comments by theme.

Table 2: Number of Open-Ended Comments on Each Emerging Theme

Established or Emerging Theme	Count of Open-Ended Comments
Social and Emotional Health	72
Workforce	66
Essential Care Partner Support	55
Nursing Home Policies and Practices	51
Shared Accountability for Quality Monitoring and Improvement	48
Cohorting Residents and/or Nursing Home Design	46
Testing and Screening	39
Equipment, Supplies, and PPE	33
Funding	27
General Policy Guidance and/or Requirements	24
Communications	23
Quality Control Policies and Practices	20
Other	17

Established or Emerging Theme	Count of Open-Ended Comments
Data Reporting	11
Surveys and Assessments	5

Further analysis by Commission objective and theme is provided in the following tables. Commission discussion of the public input focused on identification and integration of actionable proposals put forward by the public; therefore, priority actions that emerged from these discussions are outlined in successive paragraphs.

Objective 1: Identify best practices for facilities to enable rapid and effective identification and mitigation of transmission of COVID-19 and other infectious diseases in nursing homes.

Many open-ended comments corresponding with Objective 1 focused on direct provision of PPE and robust testing and screening supplies to allow for near universal testing of staff and residents in nursing homes. Responses also noted the need for direct support of the workforce through expanded hazard pay and training, as well as enhanced workforce monitoring and coordination across facilities to provide redundancy and support for facilities and communities facing staffing constraints due to community outbreaks.

Table 3: Number of Open-Ended Comments on Objective 1 Themes

Themes	Count
Testing and Screening	20
Equipment, Supplies, and PPE	9
Funding	8
Data Reporting	6
Workforce	5
Quality Control Policies and Practices	4
General Policy Guidance and/or Requirements	3
Nursing Home Policies and Practices	3
Shared Accountability for Quality Monitoring and Improvement	3
Cohorting and/or Nursing Home Design	2
Communications	1

Quoted and Summarized Open-Ended Comments:

- “As the first case of COVID-19 was announced ... we locked down all long-term care facilities and assisted living communities. We did that as a collective on March 8, 2020. We began meeting daily via phone conference with nursing homes, assisted livings, and independent living senior housing, public health, and emergency management. We discussed protocols and practices to identify and isolate unwell residents, PPE and testing. We have had zero cases.”
- “The residents are in jeopardy of infection from poor cleaning standards ...”
- Provide (at no cost to nursing homes) all equipment and swabs necessary for rapid results testing on-site in nursing homes, as well as an ongoing supply of PPE including gowns, masks, N95s and face shields. The profit margin is too low for individual facilities to be able to purchase these items
- Eliminate the practice of targeted testing and instead implement continual, thorough, & mandated testing for all residents and staff
- There should be a registry of workers available when many nurses and CNAs are sick, similar to hospital systems
- Provide funding for hero pay for staff during outbreaks and additional funding for ongoing staff supports; count training and time worked as temporary nurse aide in nursing homes towards CMS minimum 75 hours training requirement for long term workforce support
- When the first cases were detected, staff trained in infection control should have been hired to train and monitor staff, help them isolate individuals, disinfect the environment, and monitor residents
- Create a standardized reporting tool to report infection spread accurately and transparently to residents, family members, and community members

The following priority actions emerged from Commission members’ discussion of this public input:

- **Provide (at no cost to nursing homes) all supplies** necessary for rapid results testing on-site in nursing homes, as well as an ongoing supply of PPE. Low profit margins prohibit adequate procurement of these items.
- **Support** continual, thorough, and **mandated testing for all residents, staff, and visitors.**
- Identify **workers available to provide surge support**; provide **funding for hazard pay for staff during outbreaks**; count on-the-job training toward training requirements for direct care providers.

- Standardize reporting tools to **maximize accuracy and transparency of virus tracking** for residents, family members, and community members.

Objective 2: Recommend best practices as exemplars of rigorous infection control practices and facility resiliency that can serve as a framework for enhanced oversight and quality monitoring activities.

Open-ended comments corresponding with Objective 2 had a primary focus on the need for additional coordination and planning at the state, regional, and federal level on reporting and data requirements as well as for reimbursement and other payment planning. Responses noted the burden of reporting to multiple systems from both a cost and time standpoint, as well as the lack of perceived value from reporting, as analysis received back was not presented cohesively and in an easy to access format. Additionally, responses associated with Objective 2 had a similar secondary focus as Objective 1, focusing on policies that could be implemented that would support a more robust and reliable workforce. Suggestions included enhanced testing and screening availability and reliability, additional funding, and training and preparation of the workforce.

Table 4: Number of Open-Ended Comments on Objective 2 Themes

Themes	Count
Shared Accountability for Quality Monitoring and Improvement	33
Workforce	26
Nursing Home Policies and Practices	13
General Policy Guidance and/or Requirements	12
Funding	10
Cohorting and/or Nursing Home Design	9
Testing and Screening	8
Equipment, Supplies, and PPE	7
Quality Control Policies and Practices	6
Essential Care Partner Support	5
Social and Emotional Health	5
Communications	4
Other	4
Data Reporting	2
Surveys and Assessments	2

Quoted and Summarized Open-Ended Comments:

- “What I’ve seen over and over again is the issue of unfunded mandates. CMS in D.C. issues new regulatory requirements for all to follow and the 50 individual states that control the payments do not increase the payments.”
- “As with every emergency, having a plan in place is imperative. The education, preparedness and training of your staff will determine survival rates of both patients and staff. The example is set by the leaders.”
- “As front-line staff must be out of work due to illness or positive test results, there must be back-up staff who can commit to assignments of 4-6 weeks or longer.”
- “The risk to those individuals is from the virus coming into the facility from the outside, either a staff member or once visitations are allowed, from a family member. Either source can break infection control protocols. For either party, education and information on using social distancing and masking while in the outside community is critical. This is essential.”
- “Unfortunately, each home is doing things differently to try to control the situation. A clear AMDA recommendation for prevention/isolation that I could point to would help - each home is doing a mix of CDC, state Health Dept, and in-house ideas, some working better, some not at all.”
- Focus on finance reform of nursing homes and their stakeholders in US politics
- Ensure equity in the quality of care and outcomes for nursing home residents and staff of color
- Offer alternatives to nursing home services for elder care
- Prioritize advanced care planning and hospice care for residents

The following priority actions emerged from Commission members’ discussion of this public input:

- Attach **additional funding to regulatory requirements** to facilitate their implementation.
- Have an **emergency plan** in place and make sure that nursing homes **continuously educate and prepare their staff and residents** to implement that plan.
- Identify **back-up staff who can provide direct care when the regular staff is out sick** or in quarantine.
- Provide **equipment, testing, and infection control resources to nursing home staff and visitors.**
- Create a **clear single-source set of recommendations** for nursing homes and their families.

- **Offer alternatives to nursing home services for elder care.** Prioritize advanced care planning and hospice care for residents.

Objective 3: Endeavor to identify best practices for improved care delivery and responsiveness to the needs of all nursing home residents in preparation for, during, and following an emergency.

Open-ended comments corresponding with Objective 3 were most numerous. The public was especially pointed in their remarks on the social and emotional health of residents, and the ability of essential care partners to provide meaningful support to residents during the COVID-19 outbreak. Additionally, workforce training and enhancement of staffing levels, facility infrastructure, policy modifications for cohorting, and improved communication of policies for essential care partners were noted as essential.

Table 5: Number of Open-Ended Comments on Objective 3 Themes

Themes	Count
Social and Emotional Health	61
Essential Care Partner Support	55
Workforce	43
Cohorting and/or Nursing Home Design	36
Nursing Home Policies and Practices	35
Communications	12
Shared Accountability for Quality Monitoring and Improvement	12
Funding	9
General Policy Guidance and/or Requirements	9
Quality Control Policies and Practices	9
Equipment, Supplies, and PPE	7
Other	7
Testing and Screening	7
Data Reporting	6
Surveys and Assessments	1

Quoted and Summarized Open-Ended Comments:

- “My 94-year old mother is in a long-term care facility... I’m sure the intentions were good when the nursing home lockdown went into effect and probably most of us did not expect the COVID-19 crisis to go on indefinitely. Well, it has and this isolation that was intended to protect seniors is ironically killing them. Mom has dementia and cannot comprehend the situation. I go to the window every morning to let her know she is not forgotten but it’s not always a pleasant start to the day. In fact, sometimes it’s very upsetting to see the sadness and desperation on her face. The decision has been made for Mom and thousands of her peers to choose longevity over quality of life. This includes many folks on hospice for whom longevity is out of the question – they are simply robbed of their quality. For people with dementia like my mother, today is their best day. Tomorrow will be a little worse and who knows if there will be a six-months from now... We are losing precious time.”
- “It is hard to imagine an infection control scheme working well if staff is underpaid and forced to make difficult decisions for child and dependent care.”
- “While keeping loved ones safe from COVID-19 there needs to be methods to support their emotional and mental health as well with in person family/collateral contact.”
- “When nursing homes are built, the ideal is private rooms with three fixture bathrooms. Of course, the expense of building that model is often prohibitive, so the infrastructure we have in place is often buildings from the 70’s with long institutional corridors and mostly semi-private rooms. Newer homes that are built try to include more privacy and a homelike character, but financing is difficult for this level of care, so compromises are made in order to build or renovate at all...”
- “My Mom contracted COVID-19 in a skilled nursing facility and subsequently died from it. The lack of communication and transparency from the skilled nursing home is inexcusable. I was not directly informed that the nursing home was closed to visitors, nor was I provided any communication or information regarding the protocols put into place to protect staff and residents from the coronavirus. We were never given the option to make the best decision about her placement during this pandemic.”
- “The care for nursing home consumers is costly, and now the cost remains the same while the services that are paid for with that hefty fee are non-existent. Older adults are losing their cognitive capabilities, losing their physical capabilities and morale is low. “
- “CMS should continue to hold routine discipline specific COVID-19 calls. These calls have provided a great opportunity for providers to hear directly from CMS as well as ask questions and raise pertinent issues, concerns or points of clarifications and receive responses in real time. CMS should continue to provide tools such as the Focused Infection Control Self-Assessment. This tool was valuable asset in navigating COVID-19 in the long-term care and skilled nursing setting.”
- “I want to go on record as saying that I will submit to COVID testing, I will wrap up in PPE and be very diligent in sanitizing my hands etc. in order to have physical contact

with my only parent. If those guidelines are appropriate for nursing home staff, they should be more than appropriate for immediate family members.”

- The direct care staff need targeted training, adequate equipment and supplies, stress and grief support, and access to paid leave and other benefits. Addressing these needs is necessary to ensure this workforce can provide continuous, quality care for nursing home residents in emergencies and in general
- Allow hospice workers to be considered essential, work with facilities and hospice on testing to gain entry to the facility, facilitate telecommunication communication for hospice residents, and consider the unintended consequences of the 3-day qualifying stay waiver for residents on hospice who are required to revoke to get their SNF benefit
- Ensure that nursing homes have access to up-to-date treatment options for COVID-19
- End nursing homes in favor of another option for elder care

The following priority actions emerged from Commission members’ discussion of this public input:

- Provide **targeted training, adequate equipment and supplies, stress and grief support, and access to paid leave and health benefits to direct care providers.**
- Identify **alternative methods to get the physical and emotional support to residents** while their essential care support teams are unable to provide care in person
- Ensure that residents and their family members have considered **advanced care planning, hospice care, and other care options.**
- Ensure that nursing homes have **access to up-to-date treatment options** for COVID-19
- **Consider the unintended consequences of the 3-day qualifying stay waiver** for residents on hospice who are required to revoke to get their SNF benefit

Objective 4: Leverage new sources of data to improve existing infection control policies and enable coordination across federal surveyors, contractors, and state and local entities to mitigate coronavirus infection and future emergencies.

Open-ended comments corresponding with Objective 4 were by far the least numerous; however, it was noted these adjustments would be critical for intervention support. Input focused on suggestions and recommendations to streamline and make data collection less burdensome; moreover, there was a call for metrics that specifically support targeted measures for infection and quality control.

Table 6: Number of Open-Ended Comments on Objective 4 Themes

Themes	Count
Other	3
Quality Control Policies and Practices	2
Shared Accountability for Quality Monitoring and Improvement	2
Cohorting and/or Nursing Home Design	1
Data Reporting	1
Equipment, Supplies, and PPE	1
Surveys and Assessments	1

Summarized Open-Ended Comments:

- Leverage the 9/26/19 CMS Final Rule on Discharge Planning as a tool to improve the control of Coronavirus in nursing homes (local, state, federal levels), supporting facilities to address problems and ensuring funds go to nursing home needs, not enforcement
- Align data collection efforts (local, state, and federal levels) to provide reliable, actionable data and clear and consistent information for the public.
- Use data to support identification of resources needed by nursing homes (including enhanced funding, PPE, testing, workforce)

The following priority actions emerged from Commission members' discussion of this public input:

- **Leverage tools** from the local, state, and federal levels **to improve defenses against and responses to COVID-19.**
- **Align data collection efforts** to provide reliable, actionable data and clear and consistent information for the public.
- **Use data to identify resources needed by nursing homes** (including enhanced funding, personal protective equipment, testing, workforce, etc.).

The Commission received 87 attachments in the form of scholarly publications, organizational briefs and memos, organizational and personal letters, news articles, and additional resources via the website-based form. These documents or websites were prioritized for review using the following matrix.

Table 7: Number of Attachments by Rating

Score	Rating	Count	Description
5	Outstanding	15	Focal point is uniquely displayed and developed; Closely aligned to the Commission objectives; Publication includes analysis, synthesis, and interpretation of ideas— leads to a sense that the piece could withstand critical analysis by experts in the discipline.
4	Very Satisfactory	22	Displays clear, well-developed focal point; Aligned to the Commission objectives; Publication includes analysis, synthesis, and interpretation of ideas throughout.
3	Satisfactory	28	Displays adequately developed focal point; Somewhat aligned to the Commission objectives; Includes analysis, synthesis, and interpretation of ideas in most parts of the publication.
2	Unsatisfactory	16	Displays a focal point, although not clearly developed; Loosely aligned to the Commission objectives; Publication includes little analysis, synthesis, and interpretation of ideas.
1	Poor	6	Assignment lacks a clear and concise point; Not aligned to the Commission objectives; Publication includes no analysis, synthesis, and interpretation of ideas.

The Commission received a summary, which included origin, key points, and score.

Attachments included multiple formats including:

- **Scholarly Articles:**
 - Past non-COVID-19 related scholarly articles on process and program improvement for nursing homes and long-term care facilities.
 - COVID-19 related scholarly articles on process and program improvement for nursing homes and long-term care facilities.
- **Grey Literature:**
 - Position Briefs, Letters, and Memos from practice groups and network organizations representing nursing home and long-term care providers and facilities.
 - Industry reports and white papers.
 - Investigative reports.

- State and local policies and guidance
- News articles, blog posts, and personal accounts
- Marketing pitches from industry stakeholders for specific equipment/tools.

Attachments with scores of 3, 4, or 5 were mapped to these categories, and the results are noted in the following chart:

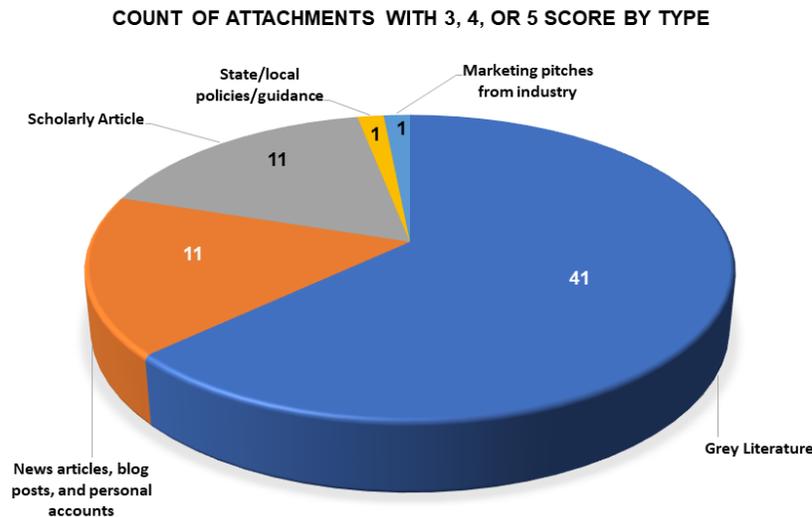


Figure 3: Distribution of Content Types for Attachments Scoring 3 – 5

The following table lists the identification numbers and attachment summaries.

Table 8: Attachment Summaries

ID	Attachment Summary
1	Article: NH fought federal emergency plan requirements for years and how to rectify it for the future
4	Scottish Article: Scotland move to national care homes and the recommendation that US also move to that model
10	2020 Letter from Congress: A clinician list would be of enormous value for public health agencies to address preparedness for influenza, norovirus, and other seasonal outbreaks as well as another emergency uses during the COVID-19 pandemic
11	2018 Letter submission about adequate medical oversight and establishing and maintaining a national database of Nursing Home medical directors
12	Submitted Public Comment on Examining the COVID-19 Nursing Home Crisis – The Society for Post-Acute and Long-Term Care (PALTC)
13	Article on 5 Keys to Solving COVID-19 Crisis

ID	Attachment Summary
14	Whitepaper about reopening America and managing COVID risk for nursing home population in six parts
41	Article on the impact of peer mentoring of loneliness, depression, and social engagement in long-term care from cohorting/grouping residents
46	Investigative report focused on performance data between for-profit nursing homes and not-for-profit nursing homes
48	NY State Senate letter to Gov. Cuomo: Recommendations to address adult care facilities vulnerabilities exposed during the COVID-19 crisis at nursing homes, adult homes, and assisted living facilities
79	Resource letter: Social Workers working in Nursing Homes - Support System/Group
93	Whitepaper: Behavioral Healthcare in Long Term Care Facilities under COVID-19 Restrictions: A Blueprint for Mental Health Crisis
95	NYT Article: Nursing homes legal protections/provisions included in the NY budget bill to protect against lawsuits that are COVID-19 related
96	Policy: Indiana State Department of Health Essential Family Caregivers in Long Term Care Facilities
97	Article outlining the importance of implementing guidance for the need of having "an essential family caregiver" program to support residents during uncertain times
98	Excerpt subchapter from the Assisted Living Facility Regulation: 8:36-18.1-2 - Infection Control Program. Excerpt copied and pasted without any explanation/recommendation
99	Article outlining the symptoms of dementia affecting resident needs and behavior impacting staff workload. A Cognitive acuity assessment tool developed to list out the symptoms of dementia
102	Individual Contributor: Highlighting the need for a stronger presence of RNs in nursing homes and request CMS reforms to RN staffing levels
117	Visual picture highlighting Antifungal and Antibacterial Medical Textiles to interrupt pathogen transfer to corroborate the Stay Fresh Technology
133	Corporation for supportive Housing Website highlighting their integrated and supportive housing models
134	Blog post about COVID-19 nursing home conditions focused on residents' rights and provides instructions for resident empowerment during restrictions and strategies for visitation
173	Personal account - in-depth overview of experience of individual with mother in long-term care facility in Oregon, Ohio
216	Part of American Academy article on the effects of social isolation on older adults
219	Promotion of Macy Catheter for non-IV medication and fluid delivery to patients
224	Proposal to test communities through wastewater testing for COVID-19 to detect problem areas
226	Letter from Pro Senior nonprofit organization advocating for enhanced family visitation policies at national level

ID	Attachment Summary
231	The Center for Medicare Advocacy recommendations for a coordinated national solution and suspension of waivers for federal law and regulation governing nursing facilities
233	Scholarly article noting recommended strategies for overall improvement of conditions in US nursing homes based on analysis of international and domestic policy as well as site conditions in US
235	Leading Age PA making wide ranging suggestions for approach to improvement of operations and support of nursing homes in US specific to COVID-19 challenges
237	Kaiser Family Foundation report- "Improving the Financial Accountability of Nursing Facilities". (Published 2013, not COVID specific but relevant)
238	Proposed policy brief advocating for an at-home model for care versus congregate settings by the Roads to Freedom Center for Independent
239	Blog post from 7/8/20 from McKnight's Long-Term Care News site "Delaying death not enough for nursing home residents"
241	Letter from American Association of Post-Acute Care Nursing (AAPACN) suggesting two short term actions and longer-term actions to support each of the four commission areas specific to Skilled Nursing Facilities
242	Briefing from Nursing Home National Association for Home Care & Hospice (NAHC) on multiple observations of developments in the relationship of hospice providers and facilities during the COVID-19 pandemic. Focuses on access to care to hospice services in facilities
252	Personal account as article on being a caregiver for aunt pre-COVID-19, references benefits from non-visitation policies with harm caused by them and advocates for revisit of policies
255	Policy brief from American Geriatrics Society specific to COVID-19 and Nursing Homes based on information available as of 4/4/2020
258	Scholarly article highlighting best practice strategies for Geriatric providers to respond to the emergent COVID-19 pandemic within their patient bases. Recommends strategies to identify infection, manage COVID-19 cases within and outside of long-term care environments, and identify and implement national, regional, and local policies
259	American Geriatrics Society policy statement on Resource Allocation and COVID 19 - companion article to item 260. Focuses on urgent need for advance care planning, achieving justice in resource allocation, and legal considerations - companion article to item 260
260	American Geriatrics Society policy statement on Rationing Limited Healthcare Resources in the COVID-19 Era and Beyond: Ethical Considerations Regarding Older Adults - companion article to item 259
261	News article titled "Social Isolation - the Other COVID-19 Threat in Nursing Homes"
262	American Geriatrics Society policy statement on Coronavirus Disease19 in Geriatrics and Long-Term Care: An Update. Presents wide-ranging suggestions for long-term care facility management and policy including

ID	Attachment Summary
267	Letter by US Against Alzheimer's specific to COVID-19 and effect on Alzheimer's residents in long-term care facilities
270	Scholarly article highlighting results of study comparing the level of nursing staffing levels and COVID-19 cases in long-term care facilities in California
277	Letter from the Association for Linen, Uniform, and Facility Services (TRSA) highlighting proposed strategies to enhance infection prevention and employee safety while reducing costs through the outsourcing of linen management
279	Article by The American Geriatrics Society overviewing results from review of COVID-19 Infections and Deaths among Connecticut Nursing Home Residents: Facility Correlates
285	Memo from Continuing Care Leadership Coalition (CCLC), representing member long-term care facilities, highlighting best practices observed/identified by the organization to inform safety and quality improvement in nursing homes and other long-term care facilities
288	Memo from the American Health Care Association (AHCA), National Center for Assisted Living (NCAL), and the National Hospice and Palliative Care Organization (NHPCO) on Guidance on the Role of Hospice Services in LTC Facilities During the COVID-19 pandemic
291	This is a sales pitch from a software company. There are some considerations when implementing training for example, but it's an invitation to work with this company to leverage data to combat infections
293	Suggestions/Recommendations to the Coronavirus Commission for Safety and Quality in Nursing Homes from the Patients' Rights Help Line of the New York Statewide Senior Action Council
295	The Partnership for Inclusive Disaster Strategies recommendations on including Centers for Independent Living in emergency response, enforcing the Olmstead decision and pursuing cohorting design of one person per room
296	The Partnership for Inclusive Disaster Strategies recommendations to reduce staffing shortages
297	The Partnership for Inclusive Disaster Strategies request for Attorney Generals to investigate allegations at nursing homes
300	National Governor's Association call for emergency relocation of residents in congregate settings
302	Letter from the Service Employees International Union (SEIU) that advocates for updating staffing levels in nursing homes, providing staff with appropriate PPE and COVID-Testing, offering hazard pay and wages, and ensuring paid sick leave
305	Families for Better Care recommendation to use nursing home fines to enable molecule point-of-care rapid testing machine in every facility
306	Disability Rights of North America appeal to NC health department to study COVID rates and respond appropriately
307	Information for a hospice and palliative care company

ID	Attachment Summary
308	American Occupational Therapy Association appeal to provide access to PPE for therapy practitioners, extend telehealth flexibilities, and continued resident access
309	Individual contributor suggestions on changes in nursing home policies and practices including molecular POC rapid testing at every facility, one essential care partner/resident, and improving infection prevention measures
311	Neighbors to Save Rivington House recommendations on infection control, government oversight, and long-term care
315	Editorial on a staged approach to optimizing medication management during this pandemic
316	Alzheimer’s Association Policy recommendations in the areas of providing testing, reporting, PPE, communications for residents and families, and surge support
318	Medicaring.org editorial about the increase in nursing home deaths due to COVID. It is a passionate appeal to minimize the number of deaths while also addressing those residents
319	Medicaring.org recommendations on resident-centered preferences in advance of illness, treatment of respiratory failure, testing, regional planning process, and removal of bodies in a timely manner
320	Medicaring.org editorial on rethinking facility-based long-term care (the aims, financing, and place in society)
323	Unfinished tool to organize testing and interventions for residents suspected with COVID-19
324	#VisitationSavesLives This entry is an infographic
327	AARP urges action on a five-point plan to slow the spread and save lives
329	Massachusetts Advocates for Nursing Home Reform recommendations on infection control, communications, testing, workforce and cohorting
331	Consortium for Citizens with Disabilities requests the commission to provide recommendations in addressing the needs of people with disabilities and older adults in all types of congregate facilities, not just nursing homes
333	Care for Advocacy and the Rights and Interests of the Elderly recommendations to mitigate crisis of prolonged isolation in long-term care facilitates
338	Individual contributor focused on raising awareness of wound care and common to COVID 19 occurrences
341	National Governor’s Association call for emergency relocation of residents in congregate settings
347	Letter from the Avila Institute of Gerontology with several recommendations for the Commission for how nursing homes can better prepare for emergencies or pandemics
348	Detailed petition from the American Civil Liberties Union (ACLU) advocating for better care for staff and residents that includes multiple data sources for each of their recommendations

ID	Attachment Summary
349	Journal of Geriatric Emergency Medicine article that describes the challenges of how to safely transfer to and from hospital and nursing home settings and offers recommendations
352	Journal of Geriatric Emergency Medicine article that describes the challenges of how to safely transfer to and from hospital and nursing home settings and offers recommendations
355	Journal of Geriatric Emergency Medicine article that describes the challenges of how to safely transfer to and from hospital and nursing home settings and offers recommendations
356	Journal of Geriatric Emergency Medicine article that describes the challenges of how to safely transfer to and from hospital and nursing home settings and offers recommendations
358	Journal of Geriatric Emergency Medicine article that describes the challenges of how to safely transfer to and from hospital and nursing home settings and offers recommendations
361	Journal of Geriatric Emergency Medicine article that describes the challenges of how to safely transfer to and from hospital and nursing home settings and offers recommendations
362	Journal of Geriatric Emergency Medicine article that describes the challenges of how to safely transfer to and from hospital and nursing home settings and offers recommendations
369	Journal of Geriatric Emergency Medicine article that describes the challenges of how to safely transfer to and from hospital and nursing home settings and offers recommendations
370	Journal of Geriatric Emergency Medicine article that describes the challenges of how to safely transfer to and from hospital and nursing home settings and offers recommendations
381	Letter to provide the Commission with a narrative of how challenging it has been to keep COVID-19 out of their nursing home
385	Journal of Geriatric Emergency Medicine article that describes the challenges of how to safely transfer to and from hospital and nursing home settings and offers recommendations
388	Journal of Geriatric Emergency Medicine article that describes the challenges of how to safely transfer to and from hospital and nursing home settings and offers recommendations

5. Alignment with Principal Recommendations

Open-ended comments and attachments are associated with many final Commission recommendations. Many open-ended comments and attachments align to Commission recommendations by relationship of a stated problem in the comment and solution provided by the Commission recommendation(s). Some open-ended comments and attachments provided specific recommendations in direct alignment with the Commission recommendations; those are

noted in the following tables. Open-ended comments and attachments that provided recommendations unique from Commission recommendations are noted as “Unique recommendations from open comments/resources.” The following charts show the total number of associations by recommendations for open-ended comments and attachments.

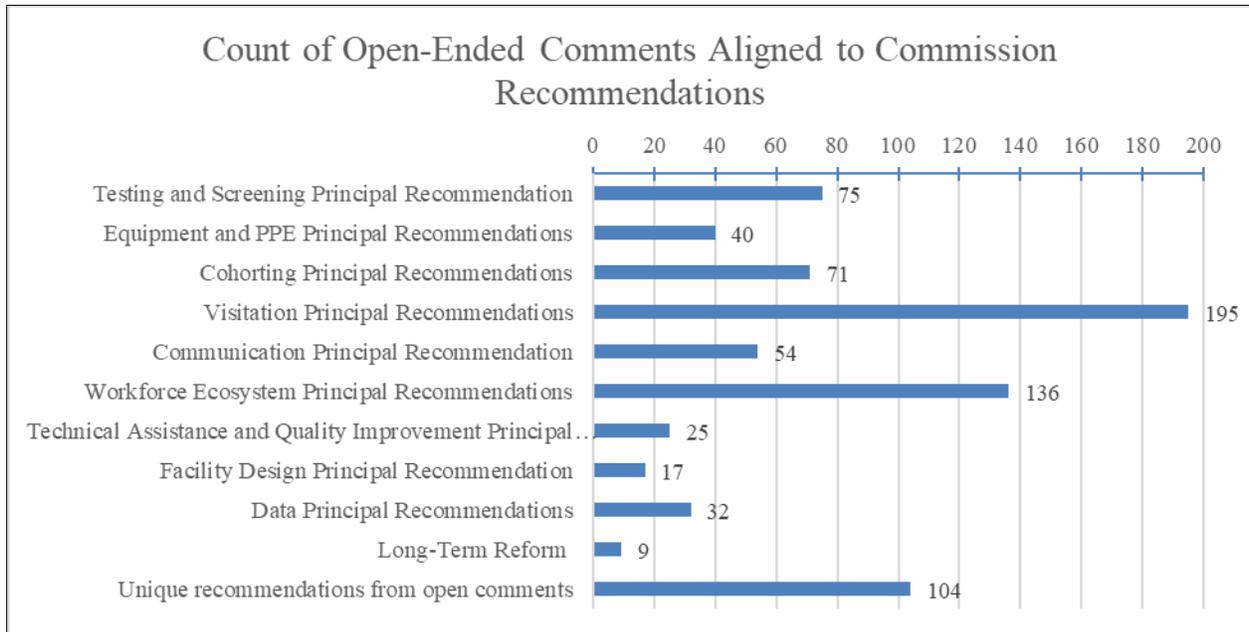


Figure 4: Aligning Open-Ended Comments to Commission Recommendations

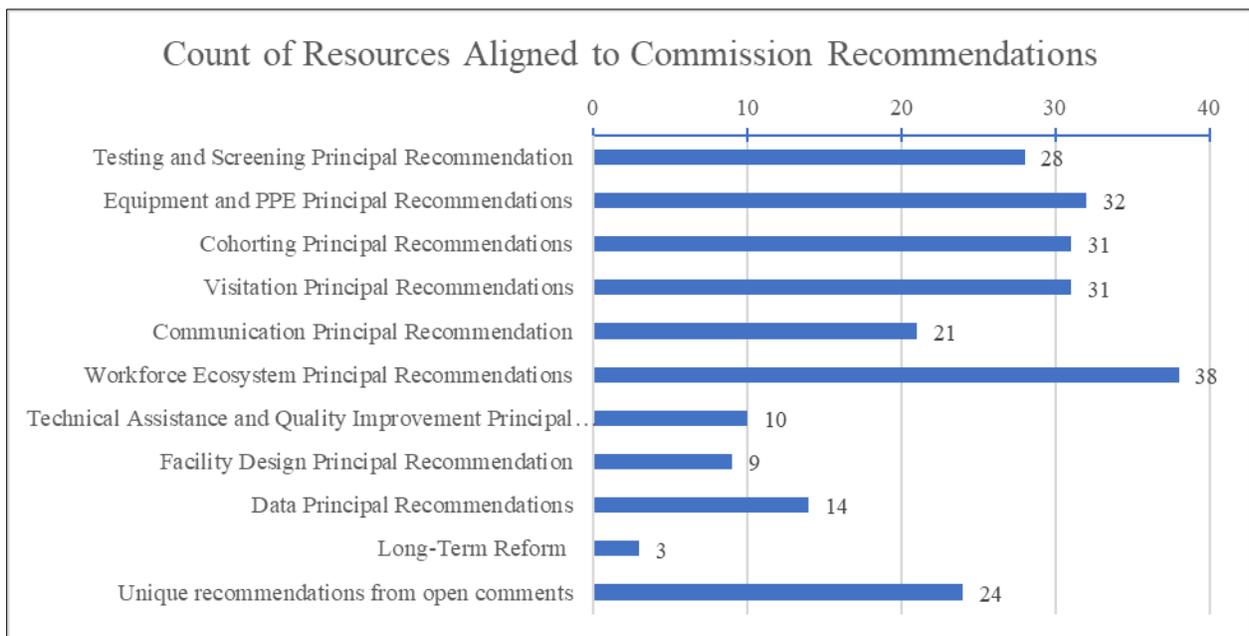


Figure 5: Aligning Resources to Commission Recommendations

5.1. Infection Prevention and Control

Six principal recommendations were developed by the Commission in the infection prevention and control category grouping. The Commission was influenced by public input from essential care partners, nursing home staff and administrators, and industry representatives, especially in consideration of the balance between infection prevention and control policies (e.g., cohorting and restricted visitation) and emotional health and well-being of residents. To support an adjustment of policies to lessen the impact and allow for some measure of visitation and support, the Commission noted that enhanced training of staff, provision of PPE, and availability of rapid testing would be crucial to do so without opening the door to increases in infection.

Testing and Screening Principal Recommendation:

- Principal Recommendation 1A: Immediately develop and execute a national strategy, coordinating with federal partners and SLTT authorities, for testing and delivering rapid turnaround of results (i.e., results in less than 24 hours) in nursing homes, in combination with CDC-recommended screening protocols. Allow nursing home owners and administrators to tailor the strategy based on community prevalence and resource availability in partnership with federal and SLTT authorities.

Summary: Addresses public input noting the need for more widely available and rapid testing and screening to support cohorting and visitation policies that can enhance social and emotional health and critical workforce availability. Notes the importance of increasing the protection of existing workforce members as many facilities are already understaffed and struggle to recruit. Enhanced testing and screening was widely noted as the best solution to ensure the efficient use of staff across facilities, especially considering staff supporting multiple sites.

Count of Aligned Open Comments: 75

Specific Recommendation(s) from Open Comments:

- Require more robust testing and screening of residents (not just those with high fever) to capture additional infectious residents before they are contagious
- Require testing for staff traveling between facilities
- Implement and support widespread, continual, and mandated testing for all nursing home staff
- Complete testing prior to admission or transfer from outside facilities
- Provide a direct provision of tests to nursing homes
- Prioritize nursing homes in first tier testing and test processing
- Guarantee by federal order sufficient testing materials and resources for nursing homes

Count of Aligned Attachments: 28

Specific Recommendation(s) from Attachments:

- Begin immediate and repeated rapid-result testing of all residents and staff of nursing homes
- Require facilities to test all nursing home workers and residents at least weekly
- Provide nursing homes with priority access to rapid response point of care testing, make more tests and related supplies available, and expand capacity of testing labs to expedite result times
- Implement a molecular point-of care rapid testing machine at every nursing home
- Review measures to ease the challenge of testing costs borne by facilities
- Ensure funding and support for actions required to meet new guidelines by facilities
- Institute cost-based reimbursement

Equipment and PPE Principal Recommendations:

- Principal Recommendation 2A: Assume responsibility for a collaborative process with federal and SLTT partners to ensure nursing home owners and administrators can procure and sustain a three-month supply of high-quality supplies of PPE. This process must provide accountability and oversight.
- Principal Recommendation 2B: Provide specific guidance on the use, decontamination, and reuse of PPE, working with federal partners, including CDC, FDA, and OSHA.
- Principal Recommendation 2C: As needed, collaborate with other federal and state agencies to provide guidance on training to all clinical and nonclinical facility staff on proper use of PPE and equipment, according to available manufacturer specifications.

Summary: Addresses public input noting the need for enhancement of PPE supply chain to ensure safety of residents and nursing home workforce.

Count of Aligned Open Comments: 40

Specific Recommendation(s) from Open Comments:

- Provide a direct provision of PPE to nursing homes
- Ensure adequate PPE is provided to all nursing homes for staff and visitors
- Track PPE locally, statewide, and regionally
- Build stockpile to prepare for a surge/ensure access to resupply
- Prioritize nursing homes with or higher than hospitals

Count of Aligned Attachments: 32

Specific Recommendation from Attachments:

- Provide nursing homes with priority access to PPE

Cohorting Principal Recommendations:

- Principal Recommendation 3A: Update cohorting guidance to balance resident and staff psychological safety and well-being with infection prevention and control.
- Principal Recommendation 3B: Update cohorting guidance and reimbursement policy to address differences in nursing home resources (e.g., facility, infrastructure, staff).

Summary: Addresses the public input noting the importance of social and emotional health and need for evidence-based policies regarding cohorting, nursing home design, and visitation. The public noted that there is significant work to be done as to the costs and benefits of restrictive policies to prevent outbreaks versus the consequences of minimal care and decreased socialization.

Count of Aligned Open Comments: 71

Specific Recommendation(s) from Open Comments:

- Require hospitals to test residents 48 hours prior to discharge to a nursing home
- Never require facilities to accept residents with highly infectious disease
- Study effects of isolation and lack of visitation on residents with mental health conditions

Count of Aligned Attachments: 31

Specific Recommendation(s) from Attachments:

- Relocate residents to a one person per room setting with community care and appropriate staffing
- Implement peer mentorship programs in facilities to combat loneliness and depression
- Allow residents to determine visitation practices for their personal requirements
- Establish an expedited Transition Taskforce that would bring together key stakeholders, policy and decision makers, providers, experts, and advocates to identify systemic barriers and create innovative solutions for cohorting

5.2. Quality of Life – Visitation and Communications

Five principal recommendations were developed by the Commission in the quality of life category grouping. The Commission noted how important addressing the quality of life, especially emotional and mental well-being, of nursing home residents is to the public. Moreover, the Commission noted the call for essential care partners to be able to return to supporting their loved ones. The Commission also recognized the importance of planning and timely communication as a central to quality of life concerns outlined in the public input.

Visitation Principal Recommendations:

- Principal Recommendation 4A: Emphasize that visitation is a vital resident right. Update and release consolidated, evidence-based guidance on safely increasing controlled, in-person visitation prior to federal Phase 3 reopening.

- Principal Recommendation 4B: Update and release consolidated, evidence-based guidance on effectively planning for and implementing virtual visitation tools and techniques.
- Principal Recommendation 4C: Provide resources to help nursing home staff assess and improve the mental health and psychosocial well-being of residents during and after the pandemic.
- Principal Recommendation 4D: Assess, streamline, and increase the accessibility of COVID-19-related directives, guidance, and resources on visitation into a single source.

Summary: Addresses the public input noting the importance of social and emotional health and better coordination with essential care partners. Also addresses the need for additional, timely communication with residents as to the purpose of various policies and built infrastructure adjustments due to emergencies, especially related to cohorting and other restrictive measures. Communications about provision of additional resources and/or modified programming and policies are also addressed here.

Count of Aligned Open Comments: 195

Specific Recommendation(s) from Open Comments:

- Rescind the benchmark of no newly acquired cases inside facilities for 28 days to allow for family/caregivers to visit residents
- Allow residents to identify 1-2 visitors (not limited to family) who undergo screening, testing, and safety precautions (PPE) for scheduled weekly visits
- Require nursing homes to have resources to enable some level of family visitation now
- Add mental health boosting activities including social interaction to residents' care plans during times of emergency
- Ensure individual care plans address total well-being needs of residents regardless of context

Count of Aligned Attachments: 31

Specific Recommendation(s) from Attachments:

- Require facilities to establish policies and procedures for how to designate and utilize an essential care partner
- Allow residents to designate one "compassionate caregiver" who can visit the resident daily and follow the same screening, testing, and PPE protocols.
- Continue preventative isolation of members who prefer and allow visitation in separate area for residents who prefer that
- Lift the restrictions on visitations
- Allow for the managed admission of both primary and behavioral health clinicians to sites for direct, in-person care and support of these residents
- Implement peer mentorship programs in facilities to combat loneliness and depression

Communication Principal Recommendation:

- Principal Recommendation 5A: Increase specificity and expand breadth of guidance on communications between nursing home staff, residents, and families.

Summary: Addresses the public input noting the importance of unified, accessible, and streamlined communication, including about nursing home policies and protocols.

Count of Aligned Open Comments: 54

Specific Recommendation(s) from Open Comments:

- Make family councils mandatory, not optional
- Increase essential caregiver contact via Skype/video tech with family members
- Set up regular times for provider and family member communication, and encourage providers to contact families on a regular basis to provide updates on residents

Count of Aligned Attachments: 21

Specific Recommendation(s) from Attachments:

- Require transparency around COVID-19 data (cases and deaths) in nursing homes, transfer and discharge rights, and provider relief funds utilization
- Facilitate ongoing meaningful engagement of residents, families, and their advocates
- Ensure any family member who had visitation rights to see their family member prior to a pandemic declaration is provided with the right to obtain regular updates on resident’s status as well as afforded assistance by the Ombudsman and the facility staff in arranging video calls

5.3. Workforce—Ecosystem and Technical Assistance

Ten principal recommendations were identified by the Commission in the workforce category grouping. The Commission noted the public’s views that a stable workforce with appropriate staffing to resident ratios in emergencies saw better outcomes. Additionally, the Commission noted the public’s perspectives that increased infection prevention and control training for and availability of staff would allow for heightened facility preparedness and functionality.

Workforce Ecosystem Principal Recommendation(s):

- Principal Recommendation 6A: Mobilize resources to support a fatigued nursing home workforce and assess minimum care standards.

- Principal Recommendation 6B: Provide equity-oriented guidance that allows nursing home workforce members to safely continue to work in multiple nursing homes while adhering to infection prevention and control practices.
- Principal Recommendation 6C: Support 24/7 RN staffing resources at nursing homes in the event of a positive SARS-CoV-2 test within that facility.
- Principal Recommendation 6D: Identify and immediately leverage certified infection preventionists to support nursing homes' infection prevention needs.
- Principal Recommendation 6E: Require nursing homes to employ infection preventionist(s) with educator capabilities.
- Principal Recommendation 7A: Catalyze interest in the CNA profession through diverse recruitment vehicles; issue guidance for on-the-job CNA training, testing, and certification; and create a national CNA registry.
- Principal Recommendation 7B: Professionalize infection prevention positions in nursing homes by updating regulations at 42 CFR § 483.80 so more fully qualified infection preventionists are available to serve in nursing homes.
- Principal Recommendation 7C: Catalyze the overhaul of the workforce ecosystem in partnership with federal, SLTT, other public, private, and academic partners.
- Principal Recommendation 7D: Convene a Long-Term Care Workforce Commission to assess, advise on, and provide independent oversight for modernization of workforce ecosystem.

Summary: Addresses public input noting importance of protecting the workforce to ensure essential care continues to be provided; enhancing training to ensure a constant state of readiness for outbreaks; supporting critical staffing ratios proven to drive more positive outcomes; and providing funding through enhanced reimbursement rates or incentives to maintain care standards. Input included scholarly articles reviewing studies from multiple geographic areas that tied resident outcomes and infection rates to the staffing levels of various facilities.

Count of Aligned Open Comments: 136

Specific Recommendation(s) from Open Comments:

- Ensure facilities are prepared with an emergency preparedness plan; include workforce readiness
- Ensure that minimum staff to resident ratios are consistent with HR5216/S2943. 4.1 hours per resident per day to promote infection control & quality of care
- Mandate at least 4.1 hours of direct care per 24-hour period for all residents of nursing homes and at least 5.1 hours for residents of memory care wings and residents needing total care

- Require all nursing home to have an infection control manager whose job is to monitor staff to ensure compliance and prevent the spread of infection
- Hire staff trained in infection control policies to train and monitor staff, help them isolate individuals, ensure a clean environment, and monitor residents
- Ensure staff is specially trained in infection control, provide increased compensation for infection control champion(s), and offer recognition as professionals in their field
- Establish training contact hour minimums for staff
- Create registry of backup and flexible staff to backfill staff that must be out of work due to illness or positive test for nursing homes similar to hospital systems
- Increase available funding and pay for Certified Nursing Aids (CNAs)
- Mandate unified training for nursing home staff on national level

Count of Aligned Attachments: 38

Specific Recommendation(s) from Attachments:

- Require nursing facilities to pay staff hazard pay during the pandemic
- Pay staff who test positive at least their full-time salaries while they are absent from work
- Increase the minimum staffing requirements based on the well-established standards of care
- Require each facility to employ a full-time, trained infection preventionist
- Mandate new, COVID-specific, effective cleaning and disinfecting processes and procedures
- Monitor staff personal hygiene practices
- Require and provide training in proper use of PPE for staff and residents
- Require states to establish plans and contracts with appropriate facilities to provide additional capacity to provide care to residents
- Implement annual increase of \$10,000 per resident (about 12% of 2016 expenditures) would amount to \$14 billion in new funding. Half of this new funding would support improvements in staffing: increasing the number of direct care workers and staff nurses; increasing the payment rates of front-line staff to a living wage; bringing a dedicated infection preventionist on staff for each building, and increasing the engagement of the medical director. The rest would go to improvements in services, technology, infrastructure, training, testing, and supplies.

Technical Assistance and Quality Improvement Principal Recommendation:

- Principal Recommendation 8A: Identify and work to achieve funding mechanisms for—or reprioritize activities of—technical assistance providers and other contractors to increase the availability of collaborative, on-site, data-driven, and outcomes-oriented support prior to, during, and after a public health emergency.

Summary: Addresses the public input about lack of data reporting in some areas because of disincentives to report. Input included a call for additional federal and state guidance as to ratings and survey processes for nursing homes to achieve increased consistency and comparability.

Count of Aligned Open Comments: 25

Specific Recommendation(s) from Open Comments:

- Use survey data to support identification of resources needed by nursing homes (including enhanced funding, PPE, testing, workforce) rather than as a source of punishment and blame
- Institute mandatory reporting and disclosure of critical nursing home operational information to the public

Count of Aligned Attachments: 10

Specific Recommendation(s) from Attachments:

- Provide appropriate lawsuit protection for facilities
- Ensure funds are used for testing, PPE, staffing, virtual visitation, and other items that directly relate to resident care, well-being, prevention, and treatment
- Develop standard guidelines for nursing homes to build into their disaster response efforts
- Require inspection results to be posted on facility websites and nursing home compare profiles

5.4. Facility Design

Three principal recommendations were identified by the Commission in the facility design category grouping. The Commission noted public encouragement about facility design modifications that would help support person-centered infection prevention and control practices.

Facility Design Principal Recommendations:

- Principal Recommendation 9A: Identify and share with nursing homes short-term facility design enhancements to address immediate pandemic-related risks that can be implemented at minimal cost.
- Principal Recommendation 9B: Establish a collaborative national forum to identify and share best practices and recommendations; facilitate real-time learning on how to best use existing physical spaces.
- Principal Recommendation 9C: Collaboratively establish long-term priorities and seek appropriate funding streams for nursing homes to redesign and/or strengthen facilities against infectious diseases.

Summary: Addresses public input noting how design can support cohorting practices while maintaining modified programming to maintain social and emotional health of residents.

Count of Aligned Open Comments: 17

Specific Recommendation(s) from Open Comments:

- Create private rooms in a circle or spiral around a nursing station and pathways to encourage movement in spaces reducing congregation
- Create cafes or small dining rooms with reservations for meals or ordering for delivery looking like restaurants
- Build visitation centers

Count of Aligned Attachments: 9

Specific Recommendation(s) from Attachments:

- Cohort residents by COVID-19 status, with complete separation of residents and with staff dedicated to different units
- Relocate residents to a one person per room setting

5.5. Data

Three principal recommendations were developed by the Commission in the data category grouping. The Commission recognized the need for improved data reporting and synchronized analysis and interoperability as central to addressing many of the public inputs. The ability to quickly implement and improve data collection and provision methods drove the focus of the Commission on the following recommendations.

Data Principal Recommendations:

- Principal Recommendation 10A: Standardize COVID-19 data elements, improve data collection, and identify supportive actions that CMS and federal partners will take in response to key COVID-19 indicators based on nursing home-reported data.

- Principal Recommendation 10B: Create an easy-to-use, intuitive, and interactive technical infrastructure for nursing homes that streamlines the process of data reporting and consolidates dissemination of essential policy guidance, information about updated regulations, and other communications.
- Principal Recommendation 10C: Enhance HIT interoperability to facilitate better communication, improve quality measurement standards, and coordinate integration of nursing home data with data from other health organizations.

Summary: Addresses the public input noting the importance of providing a centralized collection and reporting hub for easy access by stakeholders to enable informed and coordinated decision making. Addresses the public input noting the importance of providing additional data context to enhance predictive ability of nursing homes for planning and coordination with other health facilities.

Count of Aligned Open Comments: 32

Specific Recommendation(s) from Open Comments:

- Create a standardized reporting tool that includes demographic information to report infection spread accurately and transparently to residents, family members, community members, etc.
- Require facilities to conduct and track staff education using computerized training software and electronic databases to improve the process and reduce costs
- Authorize a National Academy of Medicine study of the disproportionate impact on nursing homes that serve significant numbers of residents of color

Count of Aligned Attachments: 14

Specific Recommendation(s) from Attachments:

- Streamline reporting to local, state, and federal agencies to ensure facility staff are not pulled away from resident care to meet fragmented reporting mandates
- Gather data from every skilled nursing facility (SNF) and construct a post-acute COVID-19 plan
- Ensure NH information be made available daily on facility websites/and or on state websites with accommodations to assist limited English-speaking populations
- Create a database for tracking 2 CFR §483.70(h) and include additional data capture on associate medical directors and other physicians being paid as administration personnel
- Require transparency around COVID-19 data (cases and deaths) in nursing homes and other long-term care facilities, transfer and discharge rights, and provider relief funds utilization

6. Public Input Alignment with Long-Term Reform

An additional recommendation under consideration by the Commission that falls beyond the scope of the short-term time frame for the requested recommendations relates to finance reform. The Commission likewise recognized in the public inputs an interest in this theme. The long-term reform recommendation and associated public input is outlined in this section.

Long-Term Recommendation: Review Medicare and Medicaid rates to account for future sustained infection control, emergency management, and communication activities necessitated by the prolonged public health emergency.

Summary: Addresses public input that noted necessary interventions and modifications to nursing home policies and practices caused by the prolonged public health emergency, and potential future emergencies, were difficult for many facilities to implement and maintain due to constrained funding. Additionally, several respondents noted increased funding would (1) allow for adaptations that would lessen the negative impacts of cohorting; (2) allow for enhanced communication with healthcare providers such as hospice providers, geriatricians, dental providers, pain management providers, mental health providers, and others through technology and telehealth; and (3) create opportunity for sustained and more regular communication with essential care partners.

Count of Aligned Open Comments: 9

Specific Recommendation(s) from Open Comments:

- Increase reimbursement to compensate for additional measures required to protect residents and staff from COVID-19
- Do not allow nursing homes to charge residents or family members emergency fees, “COVID-fees,” to pay for PPE, testing, etc.
- Increase reimbursements that are based on optimal level of care, not the bare minimum
- Ensure funding and reimbursements are adjusted to allow nursing homes to implement new regulatory requirements

Count of Aligned Attachments: 3

Specific Recommendation(s) from Attachments:

- Implement annual increase of \$10,000 per resident (about 12% of 2016 expenditures) would amount to \$14 billion in new funding. Half of this new funding would support improvements in staffing: increasing the number of direct care workers and staff nurses; increasing the payment rates of front-line staff to a living wage; bringing a dedicated infection preventionist on staff for each building, and increasing the engagement of the medical director. The rest would go to improvements in services, technology, infrastructure, training, testing, and supplies.
- Increase funding from government programs, like Medicaid and Medicare
- Institute a Medical Loss Ratio for facilities

7. Additional Public Input Themes

Some public open-ended comments and attachments provided unique recommendation(s). These inputs were synthesized into themes or groupings where possible, counted, and are listed here. Some represent unique areas for additional interventions.

Table 9: Grouping Unique Recommendations

Unique Recommendations Provided by the Public (Open-Ended Comments)	Count
Provide additional nursing home oversight	12
Consider nursing home alternatives for older adults and/or people with disabilities	10
Provide additional care for residents with disabilities (e.g., deaf, dementia)	9
Allow residents to go home	9
Consider hospice workers as essential	7
Provide testing recommendations for transitions of resident care (admitting/discharging patients from hospitals and/or residents from nursing homes)	5
Ensure adequate environmental cleanliness	4
Consider ombudsman as essential	4
Promote the use of telehealth services in nursing homes	4
Provide family members with increased monitoring of rooms in facilities through camera use	3
Ensure adequate oral care	3
Consider nursing home alternatives for older adults and/or people with disabilities (Home and Community Based Services)	3
Implement contact tracing, social distancing protocols, and safety training for staff	3
Provide residents with communication devices	2
Provide additional financial nursing home oversight	2
Add specificity to vague rules and regulations	2
Ensure equal quality of care and outcomes for nursing home residents of color	2
Enforce "pay for performance" regulations	1
Engage the National Guard to support COVID relief efforts	1
Ensure assisted living facilities held to same standards as nursing homes	1
Hire a clinical social worker with a master's degree at every nursing home to assist with resident care	1
Improve the diet of residents	1
Incorporate diversity in all levels of staff	1
Mandate a geriatrician or geriatrics trained staff in nursing homes	1

Unique Recommendations Provided by the Public (Open-Ended Comments)	Count
Mandate the transition to a single unified electronic staff training platform and record keeping system	1
Do not permit Medicaid waivers to have enrollment caps	1
Observe young staff members and ensure proper infection control practices	1
Provide COVID-19 standardized treatments for nursing home populations	1
Reestablish staffing ratio guidelines based on level of resident care needed	1
Require all staff, including informal providers and administrators, to take Hippocratic oath "first do no harm"	1
Require family councils at all nursing homes	1
Require ombudsmen to be out in facilities much more frequently to talk with residents and facility staff	1
Require stricter provisions for pets	1
Review of residents' rights impact by liability protections	1
Study the Irish model for nursing homes	1
Update the system of reimbursement is sufficiently funded to assure high quality care and a meaningful life for each resident or short stay patient	1
Consider the unintended consequences of the 3-day qualifying stay waiver for residents on hospice who are required to revoke to get their skilled nursing benefit	1

Table 10: Grouping Attachments

Unique Recommendations Provided by the Public (Attachments)	Count
Continue full standard and complaint surveys through the pandemic	5
Require supervision on the night shifts, weekends, and holidays	3
Institute zero tolerance for repeated abuse and neglect	2
Designate specific nursing facilities as specialized "COVID-19 Positive Centers" using a data-driven approach	1
Encourage additional coordination between hospitals, nursing homes, and local health authorities focusing on safe transfers	1
Ensure proper tailoring of guidelines for local conditions and specific facilities	1
Institute a medical loss ratio for facilities	1
Institute cost-based reimbursement	1
Limit visitors so that there is little opportunity for exposure to SARS-CoV-2	1
Mandate decisions for testing, visitation, isolation procedures, admittance policies etc. by the State or federal DOH's so that they are not left to the discretion of the facilities	1

Unique Recommendations Provided by the Public (Attachments)	Count
Prevent designating facilities as COVID facilities that are Special Focus Facilities or SFF candidates, have fewer than 3 stars on the health inspection domain on Nursing Home Compare, have fewer than 4 stars in the staffing domain on Nursing Home Compare, or have civil money penalties (CMPs) of \$5000 or more imposed in the prior three years (including CMPs on appeal)	1
Provide FEMA reimbursement through Public Assistance Category B funds to provide non-congregate temporary sheltering for people evacuating from skilled nursing facilities and other institutional settings and reimbursement for providing the support and wrap around services to people that have relocated to a cohort setting	1
Provide nursing homes with medication management tools in a crisis	1
Provide telemedicine and make telehealth treatment guidelines permanent	1
Require cameras in resident rooms	1
Require staff to make daily notes and medical records on the residents available to family members especially the POA's during the pandemic	1
Streamline sources of guidelines/recommendations and ensure properly synced with additional levels of government as well as other healthcare organizations	1
Test communities through wastewater testing for COVID-19 to detect problem areas	1
Urge federal, state and local governments and health authorities to stipulate that, in the chain of events leading to reopening businesses and buildings, that PALTC facilities, where older adults most at risk of serious illness or death from COVID-19 reside, be the last to open to visitors and outside contractors and vendor	1
Require a Health Equity Impact Assessment into the Certificate of Need (CON) process used by states focusing on closures and effect on low-income, rural and urban, Black and Latinx, low-income communities, women, LGBTQ people and people with disabilities	1
Mandate facilities have trained staff position designated to pandemic response and implementation planning	1
Require advance planning to identify additional surge capacity space for nursing home resident beds in emergencies	1
Enact protections against retribution and for nursing home workers who report problems and abuse	1
Ensure survey agencies and organizations have adequate staffing to ensure robust coverage and ability to follow-up directly with families on complaints	1

Appendix F: Commission Charter

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Coronavirus Commission for Safety and Quality in Nursing Homes

Charter and Operating Principles

Background

In response to the 2019 global coronavirus pandemic, which has disproportionately impacted older adults and nursing homes residents in the U.S., the Centers for Medicare & Medicaid Services (“CMS”) announced an independent commission (hereinafter, “The Coronavirus Commission for Safety and Quality in Nursing Homes” or the “Commission”) to address safety and quality in nursing homes. CMS tasked the Health FFRDC, operated by The MITRE Corporation (hereinafter, “MITRE”) to convene and facilitate the Commission. MITRE will independently author a report of the Commission’s findings and recommendations, to be delivered to CMS along with a report summary, by September 1, 2020.

Commission Objectives

The main purpose of the Commission is to solicit lessons learned and recommendations for future actions to improve infection control and safety procedures at nursing homes.

Specifically, the Commission is charged with

1. Identifying best practices for facilities to enable rapid and effective identification and mitigation of transmission of COVID-19 and other infectious diseases in nursing homes, and specifically to identify 3 to 5 recommendations that can be implemented both immediately and long-term, taking into consideration the wide array of individuals including residents, staff, visitors, essential and non-essential personnel, that interact with nursing homes.
2. Recommending best practices as exemplars of rigorous infection control practices and facility resiliency that can serve as a framework for enhanced oversight and quality monitoring activities, and specifically to aim to provide 3 to 5 recommendations on best practices that can be incorporated into a larger guidance/policy framework for oversight and quality monitoring. (Recommendations should include prevention and mitigation methods for inclusion in guidance, reporting requirements, survey tools, enforcement considerations, and improvement activities.)
3. Endeavoring to identify best practices for improved care delivery and responsiveness to the needs of all nursing home residents in preparation for, during, and following an emergency, and specifically to provide 3 to 5 recommendations on care delivery and management that can be immediately

implemented within nursing homes to address the Coronavirus pandemic as well as 3 to 5 recommendations for long-term improvements.

4. Leveraging new sources of data to improve existing infection control policies and enable coordination across federal surveyors, contractors and state and local entities to mitigate Coronavirus and future emergencies, and specifically to provide best practices for an analytic plan to monitor infection control and recommendations to create a methodological framework for using data to enhance coordination across all the above entities.

The Commission's findings and recommendations will inform and guide the development of an independent report and report summary prepared by MITRE, which will be submitted to CMS by September 1. MITRE will be solely responsible for ensuring the report and report summary are objective and accurately represent the Commission findings and recommendations.

Commission Structure

The Commission members are a diverse group of leaders, including industry experts, clinicians, resident/patient advocates, medical ethicists, nursing home administrators, academics, infection control and prevention professionals, state and local authorities, and other stakeholders whose expertise will benefit the areas on which the Commission will focus. All Commission members will have an opportunity to voice their views and opinions. MITRE is the convener of the Commission.

Commission Members

Commission members are appointed by MITRE based on their relevant background, subject matter expertise, and leadership.

Commission members may not assign delegates to attend or listen to convenings on their behalf, nor should Commission members invite others to listen in to convenings. The kickoff meeting is a convening.

Members will:

- Provide input and feedback to achieve the above Objectives during convenings and as requested by MITRE.
- Commit best efforts to attend all Commission convenings, and at least 4 of the 5 planned convenings, and participate in debriefing discussions as requested. When unable to attend a convening, the member will notify MITRE.
- Work collaboratively and respectfully with other members to achieve the above Objectives.
- Serve, as requested, on subcommittees or working groups that may be formed to explore specific issues between the full Commission convenings.
- Commit best efforts to complete any pre-work assigned in preparation for

- convenings.
- Commit best efforts to adhere to the Virtual Behaviors described later in this document.

MITRE as Convener, Moderator, and Report Author

MITRE serves as the convener of the Commission, providing logistics support for Commission events, including the development and dissemination of convening materials and briefings. MITRE will consult with CMS and Commission members as it develops and finalizes agenda and materials in support of the Commission's convenings.

MITRE is responsible for documenting Commission member attendance, input and feedback at each convening. MITRE is also responsible for determining how to handle issues that may arise with respect to a member's participation, such as if a member fails to attend multiple convenings. MITRE is responsible for briefing CMS leadership on progress on a regular basis.

MITRE's Chief Medical Officer serves as the Commission moderator and provides guidance on planning, facilitating, and executing Commission convenings. The moderator is not a member of the Commission and maintains neutrality in all convenings and discussions.

The moderator:

- Provides guidance to the Commission and establishes a collaborative and action-oriented culture to achieve the Objectives described above.
- Provides strategic guidance on Commission agenda and convening materials.
- Moderates Commission convenings, ensuring that all members have an opportunity to contribute, and that members adhere to their responsibilities and the Rules of Conduct.
- Determines the best approach to consensus-building and decision-making.
- Provides guidance on the first draft and final versions of the report and report summary.
- Represents the findings and recommendations of the Commission in discussions with CMS and the public as requested.
- Maintains objectivity and independence in all communications on behalf of the Commission.

As the preparer of the report and report summary, MITRE will create a framework for prioritizing the Commission's findings and recommendations. MITRE will independently prepare draft and final versions of the report and report summary for submission to CMS. Commission members' ability to review and comment on the

draft and final reports is denoted below under “Commission Scope and Authority.” CMS may also review and comment on draft reports.

MITRE is not responsible for the publication of the report and report summary delivered to CMS. CMS owns the report and report summary and makes all decisions regarding its eventual distribution. CMS may choose to publish all or any parts of the report and report summary and in doing so must indicate if any content has been altered or removed from the final versions delivered to CMS by MITRE.

Invited Guests

CMS Leadership—It is anticipated that CMS leadership will participate as invited guests in a listen-only mode during Commission convenings, unless present as invited speakers. It is not anticipated that CMS invitees will necessarily listen in on breakout sessions during the convenings where members work in small groups; this will be determined by the moderator in discussion with the members.

Federal Partners or Other Experts—Other Federal partners or other subject matter experts may attend portions of one or more Commission convenings as guests at the recommendation of Commission members or CMS, and concurrence by the MITRE moderator. Invitations would be extended by MITRE. They may participate as interested constituents or serve to inform the Commission’s discussions.

Commission members will be informed when guests are present and when they leave a convening.

Recording of Convenings

MITRE may elect to record Commission convenings to verify content and accurately capture discussions. The video and audio recordings will be maintained by MITRE and will not be released to the public; the documentation will be marked sensitive, proprietary, and confidential. Further, MITRE will take measures to protect the video and/or audio recordings from disclosure. The Commission members signal their consent to these recordings through their participation in the convening, and MITRE will remind participants at the outset of a meeting that it is being recorded. Transcription of recordings will be made and shared with the Facilitator and Moderator.

Separate recording of the convenings by any meeting attendees but MITRE is prohibited.

Commission Scope and Authority

The Commission can, through MITRE, request information, data or presentations from CMS that may help it in its work. CMS will share that information or data if available and releasable and MITRE will coordinate with CMS on the provision of information or data

to the Commission and/or arranging for presentations to the Commission.

Commission members will develop findings and recommendations on topics relevant to the Objectives based on their individual experiences, expertise, and background.

Commission members will have opportunity to comment on draft and final versions of the report and report summary prepared by MITRE and may choose to endorse the final report and report summary before submission to CMS.

The Commission does not have the authority to direct the writing of the independent report and report summary, nor may it override recommendations of other Commission members.

Neither the Commission nor MITRE has the authority to direct the actions of CMS or any other governmental authorities.

If needed, the Commission may request an Executive Session and may ask invited guests and non-Commission members to leave the convening. A member may approach the meeting moderator or facilitator about desire to go into executive session and MITRE will keep the confidentiality of the requesting member's identity. MITRE will provide guidance on how to do this.

Commission Rules of Conduct

To ensure that the Commission works collaboratively to achieve the Objectives, members will:

- Communicate with respect, candor, objectivity, and intellectual honesty during convenings and deliberations.
- Give and accept feedback in a constructive, non-defensive manner.
- Approach all interactions with the Commission as an opportunity to learn as well as to inform.
- Contribute to achieving convening objectives by thoroughly reviewing briefing materials.
- Provide qualitative and quantitative data to inform the Commission, as requested.
- Provide follow-up input or materials after each convening, as requested.
- Refrain from publicizing the findings or recommendations of the convenings without the written consent of MITRE as per the terms of the Non-Disclosure Agreement that each member has signed.

Virtual Behaviors

Because the Commission convenings will be held virtually, each member will:

- Test their technology and video conferencing/webcam capability to ensure they are functional prior to the first convening.
- Make every effort to participate where privacy of the discussion can be preserved (e.g., join from a private room and/or use headsets so that non-member cannot listen in on the meeting).
- Remain actively engaged and on-camera while others are speaking.
- Indicate that they are ready to speak as instructed by the moderator.
- Mute when not speaking unless/until called upon.
- In all other ways, conduct themselves as if in an in-person convening.

Consensus Procedures

The findings and recommendations of the Commission will inform the report and report summary written by MITRE. MITRE will independently evaluate the Commission's findings and recommendations and will work to achieve consensus among Commission members on the final recommendations. If the members do not reach consensus on a given issue, then the MITRE moderator will determine how to reflect minority and/or dissenting opinions in the final report and report summary.

Confidentiality and Chatham House Rule

To maintain the confidentiality of the Commission's work and promote candor during its convenings, members will refrain from publicizing the discussions, findings or outcomes of the convenings without the written consent of the MITRE. For more information about this topic, please refer to the non-disclosure agreement that members signed upon their acceptance of their Commission appointments.

MITRE will operate Commission convenings and discussions under the Chatham House Rule, whereby convening insights are extracted but not attributed to any Commission member or guest in any convening summaries or in the report and report summary prepared by MITRE. Commission members and all guests will adhere to this rule in any communications that follow the convenings.

**Appendix G:
Commission Memorandum of Short-Term
Recommendations – July 17, 2020**

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Coronavirus Commission for Safety and Quality in Nursing Homes Short-term Recommendations for CMS

July 17, 2020

Purpose and Context of These Recommendations

During its July 14 convening, the Coronavirus Commission for Safety and Quality in Nursing Homes (Commission) prioritized the Centers for Medicare & Medicaid Services' (CMS) July 7 request for recommendations the agency can implement in two to four weeks.¹ This memo summarizes that output. Some of the following recommendations may require actions outside the authority of CMS. However, the Commission recognizes CMS as the lead federal agency for nursing homes and their regulation, and urges CMS to continue to advocate for nursing homes and their residents with other federal agencies and states in the national response to the Coronavirus Disease 2019 (COVID-19) pandemic.

The Commission members considered established or emerging evidence in its discussions. Members noted that some issues they considered most important may require more time for CMS to address but need to be started now. The Commission will continue to discuss the themes covered in these recommendations in its remaining convenings. MITRE expects the Commission will provide more specific and additional recommendations in the final report, along with findings that reflect the emerging evidence that inform the recommendations. MITRE anticipates incorporating this memorandum as an appendix to the final report to be delivered to CMS on September 1, 2020.

The Commission recognized that CMS has taken initial steps to support access to testing and personal protective equipment (PPE) as part of the national strategy to address COVID-19 and understands these issues are not within the sole control of CMS. Members stressed that additional federal action is necessary to ensure sufficient availability of high-quality testing and PPE. Without this, and related training, the virus will continue to spread. **The Commission considers its recommendations on testing and PPE to be the highest priority for infection control.** Beyond testing and PPE, many Commission members consider hazard pay for nursing home staff to be the next most important short-term recommendation. Other recommendations focus on hotspot anticipation and resource mobilization, streamlined communication and reporting, resident- and staff-centered infection control, and an update in the Resident Assessment Instrument/ Minimum Data Set (RAI/MDS) manual.

Recommendations of Highest Priority for Infection Control

- **SCREENING AND TESTING:** Release a recommended baseline COVID-19 screening and testing strategy for nursing home residents, staff, and visitors that incorporates best/promising/emerging practices with tailored options for local adaptations based on community spread of COVID-19. Include in the strategy the type(s) of tests that should be used, for whom, and at what frequency. Deploy – via appropriate federal or state mechanisms – additional funding to provide and sustain the equipment, training, and supplies essential to implement a nationwide screening and testing strategy.
- **PPE:** Ensure all nursing homes have adequate and high-quality supplies of PPE. Provide up-to-date guidance on the use and reuse of various types of PPE. Ensure nursing homes are prioritized at local,

state, and national levels for PPE acquisition and that a federal strategy exists to address PPE shortages.

Further Recommendations for Short-Term Actions

- **HAZARD PAY:** Immediately implement hazard pay for direct services staff of nursing homes through appropriate federal or state funding mechanisms.
- **HOTSPOT ANTICIPATION AND RESOURCE MOBILIZATION:** Use predictive analytics to anticipate the need for nursing home workforce support across the nation. Deploy emergency management, infection control, and capacity-building support to nursing homes in collaboration with state-based strike teams.
- **COMMUNICATION AND REPORTING:** Initiate a single, bidirectional user interface to release national guidance and data to nursing homes, and to simplify COVID-19 data collection from nursing homes.
- **RESIDENT- AND STAFF-CENTERED INFECTION CONTROL:** Incorporate resident and staff psychological safety and wellbeing into the nursing home infection prevention and control program (IPCP), including specific, evidence-based guidance on:
 - Cohorting of residents and staff to minimize disruption of daily routines while promoting rigorous infection control practices.
 - Maintaining resident contact with external support systems through facilitation of physically distanced and/or virtual visits.

Facilitate collaboration among organizations to share emerging best practices that balance resident and staff needs with infection control.

- **CODING:** Modify RAI/MDS manual coding instructions for isolation because of active infectious disease (Chapter 3 of the MDS 3.0 RAI Manual (O0100M)) to allow capture of care and services provided to persons with or suspected to have COVID-19 who are isolated per CDC and/or CMS guidelines.

Commission Member Review of This Memo

All members had the opportunity to review this memo in its final draft form (just prior to this version). Many members endorsed the memo without editorial comment. A handful of members offered edits to give the recommendations more specificity; because there was not time to recirculate fully-revised recommendations to the entire Commission, MITRE will share those inputs for the group to discuss in future convenings. One member agreed the memo reflects the discussion of the majority; however, they did not endorse the priorities reflected. For this member, cohorting is second only to the use of PPE.

ⁱ Note: This memo is delivered in rapid-turn following the Commission's July 14, 2020 convening. During that meeting, the Commission members were unaware of the development, announced later on July 14, of a federal initiative to distribute rapid point of care testing to nursing homes designated for prioritization by CMS. Thus, the Commission members did not discuss this development. Some members have noted that they wish to discuss the need for a specific recommendation regarding this new initiative, which MITRE anticipates will be forthcoming.

Appendix H: Nursing Home COVID-19 Data Limitations

Given the broad impact of the COVID-19 pandemic on nursing homes and the desire to make informed decisions, policymakers at all levels have been interested in obtaining high-quality, timely, and actionable COVID-19 data. However, a variety of limitations exist with these data.

Surveillance data on COVID-19 are often incomplete and can lead to an undercount of cases and deaths.²⁸⁶ There are multiple specific limitations and cautions to consider with common COVID-19 data types, including issues of representativeness; bias; measurement and sampling error; time periods of reporting; and scale or location factors.²⁸⁷

Approaches to collecting and reporting COVID-19 data in nursing homes can vary at the federal, state, and local level. Although CMS instituted new reporting requirements for all federally-certified nursing homes with the aim of gathering more complete and standardized COVID-19 data, discrepancies between federal and state data are still apparent in some instances – such as when certain states report cumulative cases and deaths across multiple types of long-term facilities or over a different timeframe compared to the federal government.²⁸⁸ Some data elements may be publicly available only from certain states but not others (or at the federal level). Data definitions can also differ, such as criteria for determining resolved or suspected cases.²⁸⁹

CMS has highlighted that ongoing COVID-19 data reported to CDC's NHSN system is preliminary and subject to fluctuations, including changes made by nursing homes given the opportunity to correct their submitted data when needed.²⁹⁰ In addition, CMS has acknowledged several limitations of the nursing home COVID-19 data, including variability in retrospective reporting, inaccuracies due to the challenge faced by facilities adapting to new reporting requirements, and the impact of variable access to COVID-19 testing on case identification.²⁹¹

²⁸⁶ United States Government Accountability Office. (2020, July 30). *COVID-19: Data Quality and Considerations for Modeling and Analysis*. <https://www.gao.gov/products/GAO-20-635SP>

²⁸⁷ National Academies of Sciences, Engineering, and Medicine. (2020, June 11). *Evaluating Data Types: A Guide for Decision Makers using Data to Understand the Extent and Spread of COVID-19*.

<https://www.nap.edu/catalog/25826/evaluating-data-types-a-guide-for-decision-makers-using-data>

²⁸⁸ Chidambaram P and Garfield R. (2020, June 15). *Limits and Opportunities of Federal Reporting on COVID-19 in Nursing Facilities*. Kaiser Family Foundation. <https://www.kff.org/coronavirus-covid-19/issue-brief/limits-and-opportunities-of-federal-reporting-on-covid-19-in-nursing-facilities/>

²⁸⁹ Chidambaram P and Garfield R. (2020, June 15). *Limits and Opportunities of Federal Reporting on COVID-19 in Nursing Facilities*. Kaiser Family Foundation. <https://www.kff.org/coronavirus-covid-19/issue-brief/limits-and-opportunities-of-federal-reporting-on-covid-19-in-nursing-facilities/>

²⁹⁰ Centers for Medicare & Medicaid Services. (2020, August 9). COVID-19 Nursing Home Data.

²⁹¹ Centers for Medicare & Medicaid Services. (2020, June 4). *Nursing Home COVID-19 Data Release External FAQs*. <https://www.cms.gov/files/document/covid-nursing-home-data-release-external-faqs.pdf>

**Appendix I:
Commission Recommendations Overview Presentation –
August 14, 2020**

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Coronavirus Commission on Safety & Quality in Nursing Homes

Recommendations Overview

Preliminary Deliverable in Advance of Final Report. Content Subject to Change.

August 14, 2020

Commission Process & Endorsement

- **Commission Formation & Focus.** The 25-member commission kicked off on June 23; it then convened six times throughout July to discuss and formulate recommendations in four focus areas. CMS staff and other federal guests joined these sessions in listening mode. CMS advised commission members to limit the scope of their discussions and recommendations to nursing homes that are solely regulated by CMS, which excludes nursing homes that operate solely under the purview of the VA. CMS's ability to tailor, implement, and monitor the impact of the Commission's recommendations will be subject to the varied authority granted to federal and state regulators in this space.
- **Public Input.** MITRE sought comments from organizations and individuals interested in informing the Commission's work via two mechanisms: (1) a public-facing email inbox, and (2) a website-based structured engagement form. More than 600 submissions were received. Many themes emerged; visitation and workforce themes were of an order of magnitude higher than all others. The final report will provide greater detail about this activity.
- **Purpose of This Slide Deck.** MITRE prepared this preliminary slide deck in advance of a detailed report to be delivered to CMS on September 1. The content is informed by Commission member input, public input via the Commission website, and CMS actions through August 11.
- **Commission Member Endorsement of Contents.** Commission members had the opportunity to review this slide deck from Aug. 11 – 13. Twenty-one members generally approve; discussion continues in areas where opinions diverge. MITRE has included notations on slides where there is lack of Commission member consensus or a dissenting opinion on a recommendation or action step. MITRE has also denoted where certain text is derived solely from public input (P) or MITRE (M); this content may not reflect Commission member discussion or opinion but was included to address a key gap in actionable specificity.

Commission Objectives

The main purpose of the Commission is to solicit lessons learned and recommendations for future actions to improve infection control and safety procedures at nursing homes.

Objective	Related Themes
1. Identify best practices for facilities to enable rapid and effective identification and mitigation of transmission of COVID-19 and other infectious diseases in nursing homes	Testing and Screening, Equipment and PPE, Cohorting, Visitation, Workforce Ecosystem, Technical Assistance and Quality Improvement, Facilities
2. Recommend best practices as exemplars of rigorous infection control practices and facility resiliency that can serve as a framework for enhanced oversight and quality monitoring activities	Testing and Screening, Equipment and PPE, Cohorting, Visitation, Communication, Workforce Ecosystem, Technical Assistance and Quality Improvement, Facilities
3. Endeavor to identify best practices for improved care delivery and responsiveness to the needs of all nursing home residents in preparation for, during, and following an emergency	Cohorting, Visitation, Communication, Workforce Ecosystem, Technical Assistance and Quality Improvement, Facilities
4. Leverage new sources of data to improve existing infection control policies and enable coordination across federal surveyors, contractors and state and local entities to mitigate Coronavirus and future emergencies	Nursing Home Data

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Key Takeaways

The Commission put forward 9 themes and 27 principal recommendations.

- **Immediate and near-term actions by CMS (through policy or regulations, alone and with others) are necessary.** The Commission and the public alike call on CMS to continue advocating on behalf of beneficiaries based on the following principles.
 - **Residents and families must be able to connect in meaningful ways** to ensure the physical and mental well-being of the resident and to protect against neglect and abuse. To achieve positive outcomes, CMS must ensure nursing homes address this need and residents' other conditions while prioritizing rigorous infection control.
 - **Nursing home staff must be kept safe and treated with respect in the workplace**, which requires access to the right training and equipment, along with **compensation** that recognizes the risks they take, their dedication to resident safety, and the quality of the care they deliver.
 - **Nursing home management and staff can be more effective if provided with streamlined communications, reporting capabilities, and access to funds** that will support myriad additional costs, and can reduce the trauma of some emergency measures by communicating policies in advance and providing advance notice when activated.
- **CMS should work with its partners to identify funding** sufficient to fully pay for each implemented recommendation.
- **CMS must begin now to take steps to solve longer-standing, systemic issues illuminated by the pandemic.** A systems focus on long-term care financing and accountability, facility design, workforce, governance/management, technology, and data will help ensure future nursing home safety and quality. The final report will present this discussion.

Principal Recommendations (1/3)

Theme 1: Securing Testing & Screening Capabilities (slides 10 – 11)

- With federal, state, local, territorial, and tribal (SLTT) partners, **immediately develop and execute a national strategy for testing and delivering rapid turnaround of results** (i.e., results in less than 24 hours) in nursing homes, in combination with CDC recommended screening protocols. Allow nursing homes to tailor the strategy in partnership with federal and SLTT authorities.

Theme 2: Increasing PPE Supply and Use (slides 12 – 13)

- **Take responsibility for a collaborative process** with federal and SLTT partners to ensure nursing homes can procure and sustain a three-month supply of high-quality supplies of **Personal Protective Equipment (PPE) and essential equipment**.
- Work with federal partners, including CDC and FDA, to **create specific guidance on the use, decontamination, and reuse of PPE and essential equipment**.
- Collaborate with federal and SLTT partners to **provide guidance on training to all staff on proper use of PPE and equipment**.

Theme 3: Rethinking Cohorting Practices (slides 14 – 15)

- Update cohorting guidance to **balance resident and staff psychological safety and well-being with infection prevention and control**.
- Update cohorting guidance to **address differences in nursing home resources for cohorting**.

Theme 4: Prioritizing Visitation Activities (slides 16 – 19)

- Emphasize that visitation is a vital resident right. Update and release **consolidated, evidence-based guidance on safely increasing controlled, in-person visitation prior to Phase 3 reopening**.
- Update and **release consolidated, evidence-based guidance on effectively planning for and implementing virtual visitation tools and techniques**.
- **Provide resources to help nursing homes assess and improve the mental health and psychosocial well-being of residents** during and after the pandemic.
- Assess, streamline, and **increase the accessibility of COVID-19-related directives, guidance, and resources on visitation** into a single source.

Principal Recommendations (2/3)

Theme 5: Supporting Nursing Home Communications with Residents and Families (slide 20)

- Increase specificity and expand breadth of guidance on communications between nursing homes, residents, and families.

Theme 6: Strengthening the Workforce Ecosystem (slides 21 – 27)

- Address nursing home **workforce hazard pay**; assess and leverage emergency nursing home **surge support** options; and **emphasize minimum care standards**.
- Issue guidance for **on-the-job certified nursing assistant (CNA) training, testing, and licensure**; track all CNAs via a **central registry**; and **catalyze interest in the CNA profession** through diverse recruitment vehicles.
- Provide guidance **grounded in maximizing equity and preventing employee burnout that allows nursing home workforce members to continue to work in multiple nursing homes** while adhering to infection prevention and control practices.
- Require a **Registered Nurse (RN) to be present around-the-clock** in a nursing home when 10% or more of residents test positive for COVID-19.
- Identify and immediately leverage **certified infection preventionists** who can support nursing homes' infection prevention needs.
- Professionalize **infection prevention positions in nursing homes** by updating regulations at 42 CFR § 483.80 so more fully qualified infection preventionists are available to serve in nursing homes.
- Require nursing homes to **employ infection preventionist(s) with specific educator duties** (1.0FTE < 30 resident beds; 2.0FTE > 30 resident beds).
- Convene a **Long-Term Care (LTC) Workforce Commission and/or Advisory Board** to assess, advise on, and provide **independent oversight for modernization of workforce ecosystem**. (M)
- **Work with** federal, state, local, public, private, and academic **partners to catalyze overhaul of workforce ecosystem**.

Principal Recommendations (3/3)

Theme 7: Catalyzing Technical Assistance and Quality Improvement (slide 28)

- Identify and **work to achieve funding mechanisms for – or reprioritize activities of – technical assistance and other contractors to increase the availability of collaborative, on-site, data-driven support** prior to, during, and after a COVID-19 outbreak.

Theme 8: Enhancing Facility Design (slides 29 – 30)

- **Identify and share with nursing homes short-term facility design enhancements** to address immediate pandemic-related risks that can be implemented at minimal cost.
- **Establish a collaborative national forum** to identify and share best practices and recommendations; **facilitate real-time learning** on how to best use existing physical spaces.
- Collaboratively establish long-term priorities and seek appropriate funding streams for **nursing homes to redesign and/or strengthen facilities against infectious diseases.**

Theme 9: Making Data More Actionable (slides 31 – 33)

- **Improve COVID-19 data element standardization and data collection** while **identifying specific actions that CMS and federal partners will take in response** to changes in key COVID-19 data indicators based on data reported by nursing homes.
- Develop a **single, bidirectional application to serve as a central interface** for nursing home **data collection and information dissemination that includes essential COVID-19 guidance, statistics, and outcomes.**
- **Enhance health information technology (HIT) interoperability** to facilitate better communication, improve quality measurement standards, and **coordinate integration of nursing home data with data from other health organizations.**

Themes, Recommendations, and Actions

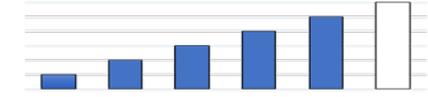
Refer to slide 35 for additional guidance on how to read the Themes, Recommendations, and Actions slides

Theme 1: Testing and Screening (1/2)

Relates to Objectives



Scale of Public Input



Problem:

Nursing homes face four challenges to successful implementation of testing and screening protocols: (1) there are testing and screening supply shortages and nursing homes may not be prioritized, (2) wait times for testing results prevent meaningful infection control; (3) there are funding gaps that prevent nursing homes from implementing staff screening and testing per existing CMS and CDC guidance; and (4) staff may lack adequate training (to administer tests properly) and sufficient resources and time (to conduct screening of visitors and staff per CDC recommendations).

Principal Recommendation:

With federal, state, local, territorial, and tribal (SLTT) partners, immediately develop and execute a national strategy for testing and delivering rapid turnaround of results (i.e., results in less than 24 hours) in nursing homes, in combination with CDC recommended screening protocols. Allow nursing homes to tailor the strategy in partnership with federal and SLTT authorities.

Recommended Action Steps:

- Work with federal and SLTT partners to ensure that nursing homes are prioritized to receive testing and screening supplies, and reporting of results, based on the prevalence of COVID-19 in facilities and in the surrounding community. Accompanying instructions should note limitations to rapid tests in terms of reliability and accuracy.
- With federal partners, develop a central point for coordinating distribution of testing kits, including molecular point-of-care testing and adequate supplies. Ensure that testing with sufficient supplies is available in one quarter, one half, three quarters, and all of the nation's nursing homes by Oct. 1, Nov. 1, Dec. 1, 2020, and Jan. 1, 2021, respectively.
- Identify and work to achieve funding mechanisms for nursing home staff to ensure nursing home capability to conduct baseline and iterative testing. In the interim, seek access to additional funding from the HHS Public Health and Social Services Emergency Fund to ensure that nursing homes have access to funding to support the scale of screening and testing required for effective operations.
 - It is assumed that visitors to the facility pay for their own COVID test or have coverage for such testing; this may be a barrier for some populations and this potential access barrier should be assessed and solution devised, at least to enable entry of essential care partners.

CMS actions to date:

- With CDC, released iterative guidance outlining details for screening and testing of residents, staff, and visitors. (2), (8)
- With HHS, began providing rapid point-of-care diagnostic devices and tests for nursing homes located in 62 hotspot geographic areas and allocated \$5B for testing through the Provider Relief Fund. (23), (27)

Theme 1: Testing and Screening (2/2)

Recommended Action Steps:

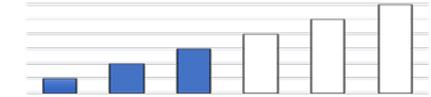
- Partner with CDC, FDA, NIH, AHRQ, and other federal agencies to ensure approved rapid tests, such as tests approved under the NIH Radx initiative, are providing accurate results.
- Provide a list of recommended tests for nursing home use.
- Provide training for all rapid testing machines and waive current Clinical Laboratory Improvement Amendments (CLIA) limitations to permit onsite testing.
- Recommend, with support of CDC and FDA, technology-based solutions that can improve daily screening processes and reduce staff burden. Include recommendations for web and phone-based applications that can quickly capture and assess screening questions without the use of staff input or assistance; and recommendations for physical screening technologies, like touchless temperature devices.
- Develop a decision tree that incorporates recommendations from Nursing Home Reopening Recommendations for State and Local Officials, QSO-20-30-NH (May 18, 2020) and that communicates the most appropriate testing strategy for residents, staff, and visitors, for baseline and iterative testing, tailored for community prevalence and other risk factor (i.e., staff travelling between nursing homes and residents receiving offsite care, including dialysis) to encourage effective intervention. The decision tree should explain what to do when a resident or staff member (1) is exposed to COVID-19; (2) is presumptively positive; (3) confirmed positive, or (4) refuses testing. (M) If a resident refuses testing under 42 CFR § 483.10(c)(6), require that the resident is isolated for the 10-14 day period pursuant to the waiver of 42 CFR §483.10 (e)(6) & (7) and that the reasoning and action are documented in the resident's record.

Theme 2: Equipment and PPE (1/2)

Relates to Objectives



Scale of Public Input



Problem:

Nursing homes do not have consistent access to an adequate quantity and quality of PPE and nursing homes may have gaps in understanding of best practices for PPE training, use, and reuse.

Principal Recommendation:

Take responsibility for a collaborative process with federal and SLTT partners to ensure nursing homes can procure and sustain a three-month supply of high-quality supplies of PPE and essential equipment. This process must provide accountability and oversight.

Recommended Action Steps:

- Work with federal partners, including ASPR and FEMA, to develop a process for procurement of PPE that includes:
 - Coordinated joint purchasing procurement and distribution of PPE with federal and SLTT agencies to ensure adequate availability and quality
 - Ability to identify status of PPE inventory, procurement pipeline, and projected demand at facility, state, and national levels
 - Established quality standards and requirements for commercial use of PPE
 - Ability for CMS to exercise its enforcement powers to ensure compliance and accountability
 - Integrated tools to monitor inventory, rotate stockpiles, manage burn rates, and maintain the federal recommendation of supplies.
- Add a requirement in the Emergency Preparedness Rule, 42 C.F.R. § 483.73, (M) to include PPE utilization in emergency preparedness and infection control protocols.
- Work with federal partners including the CDC to enhance established federal reporting sites (e.g., NHSN, PBJ) to capture detailed COVID-19 case reporting and status of PPE availability. **(See related Data recommendations.)**
- Develop guidelines for equipment and PPE shortages (i.e., procurement options when normal supply chains are unavailable or protocols for reallocation of supplies currently stored by states, facilities, and other entities).

CMS actions to date:

Issued guidance for:

- Use of PPE (3)
- State Survey Agencies: Refrain from citing facilities for lack of PPE and supplies that are beyond their control (5)
- State Survey Agencies: Use of PPE (with state and local leaders) (5)

With FEMA: issued 14-day supplies of PPE to nearly 15,000 nursing homes

With CDC: released national COVID-19 training modules

Theme 2: Equipment and PPE (2/2)

Principal Recommendation: Use, Decontamination, and Reuse: Work with federal partners, including CDC and FDA, to provide specific guidance on the use, decontamination, and reuse of PPE and essential equipment.

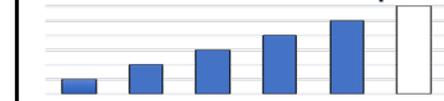
Recommended Action Steps:

- Develop and provide guidance for when to utilize different PPE such as face shields, surgical or cloth facemasks, gloves, gowns and NIOSH certified N95 respirators. This guidance must be specific to nursing home administrators, residents, staff, contractors, essential care partners, and visitors and it must identify expectations during COVID-19 outbreaks as well expectations for ramping down when appropriate. The use should be guided by the level of infection severity within the facility and geographic location.
- Release guidance for FDA-approved reuse of PPE and other essential equipment with prioritizing the use of N95 masks for high risk staff. Guidance should provide a framework for facility medical directors to implement practices most appropriate on a case by case basis.
- Release guidance on fit testing for PPE and NIOSH-approved N95 respirators.
- Establish requirements and guidance on decontamination of N95 respirators.
- Provide guidelines for equipment and PPE shortages (i.e., refresh/reuse protocols, strategies for extending limited supplies, alternative products where applicable).
- Identify and recommend acceptable methods for refresh and reuse of PPE by nursing homes.

Principal Recommendation: Training: As needed, collaborate with other federal and state agencies to provide guidance on training to all clinical and nonclinical facility staff on proper use of PPE and equipment. **(See also recommendation on Infection Preventionist under Workforce Ecosystem)**

Recommended Action Steps:

- Establish national training requirements for infection control and use of PPE for all nursing home staff and other individuals with direct and indirect contact with residents.
- Tailor training modules for PPE utilization for administrators, residents, staff, contractors, essential care partners, and visitors.
- Incorporate PPE training modules into Nursing Home Preventionist Training course and the Infection Prevention and Control Program (IPCP).
- Establish national training standards for nursing home staff based on extant core competency standards or other model standards/certifications developed by states.



Theme 3: Cohortingⁱ (1/2)

Problem:

Cohorting of nursing home residents based on their COVID-19 status has negatively affected their social and emotional health, contributing to increased anxiety and/or depression among residents.

Principal Recommendation:

Update cohorting guidance to balance resident and staff psychological safety and well-being with infection prevention and control.

Recommended Action Steps:

- Develop clear and concise guidance for cohorting using the TB Training Module 12B in the CDC Infection Preventionist training course and the *Recommended Nursing Home Phased Reopening for States* (M). Ensure CMS cohorting guidance:
 - Prioritizes resident social and emotional health and minimizes disruption of resident daily routines.
 - Includes tiers for advanced resident notification and appeals options about cohorting transfers for Phases 1, 2, and 3.
 - Includes instructions for determining, monitoring, and adapting staffing assignments that maintain cohorts while minimizing inequity of staff workload. **(see Workforce Ecosystem, Slide 23)**
 - Is adaptable based on community COVID-19 prevalence.
 - Reflects resident rights to return to original room after risk of COVID-19 transmission has been mitigated. (M)
- Modify 42 C.F.R. § 483.15 waiver to require proactive, advance communication about facility cohorting protocols with residents and residents' representatives. In the event of a positive COVID-19 test, require advance written notice to residents and residents' representatives for all transfers. Commission a study to establish an evidence-based standard for specific time requirements of advance written notice (e.g., 24-, 48-, 72-hour advance written notice) in the event of a positive test.
- Commission a study by the National Academy of Sciences, Engineering, and Medicine (NASSEM) to identify effects of cohorting for prolonged periods of indefinite duration, methods for nursing homes to address those effects, when to use isolation, and how to adapt when a vaccine emerges. (P).

CMS actions to date:

- With CDC, provided guidance on cohorting. (8), (14), (15)
- Issued 1135 emergency waivers to provide states with regulatory flexibilities to permit and support cohorting. (20)
- Continuing to allow Hospital Without Walls and Temporary Expansion Sites, mitigating the effects of workforce shortages and resident cohorting. (25)

ⁱ - Cohorting is the process of locating individuals with the same condition in the same space with the intent of reducing or eliminating interaction between infected persons with uninfected persons.

Theme 3: Cohorting (2/2)

Problem:

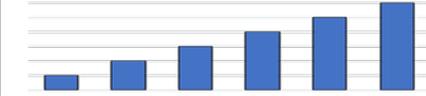
Nursing homes may not be able to implement existing cohorting guidance because of staffing, equipment, and/or environmental limitations (e.g., cleaning, tight space, lack of physical barriers, inadequate ventilation systems) and/or may be inappropriately incentivized to isolate residents.

Principal Recommendation:

Update cohorting guidance to address differences in nursing home resources for cohorting.

Recommended Action Steps:

- Recommend nursing homes have an observation unit or separate area for new admission or transfer residents. For nursing homes without sufficient facilities to create an observation unit or separate area for new residents, continue to allow a long-term care facility to cohort new admissions in another LTC facility for the purpose of observation by waiving requirements in 42 CFR 483.10(c)(5); 483.15(c)(4)(ii), (c)(5)(i) and (iv), (c)(9), and (d); and §483.21(a)(1)(i), (a)(2)(i), and (b) (2)(i). Ensure residents and residents' representatives receive ongoing communications about observation plans and actions.
- Prevent perverse incentivization by addressing and updating the reimbursement differential between cohorted and isolated residents. Specifically, modify RAI/MDS manual coding instructions for isolation because of active infectious disease (Chapter 3 of the MDS 3.0 RAI Manual (O0100M)) to allow capture of care and services provided to persons with or suspected to have COVID-19 who are isolated per CDC and/or CMS guidelines. **Note:** *Some Commission members feel this action step is logical and important; others do not.*
- Redirect and prepare Quality Improvement Network-Quality Improvement Organizations (QIN-QIOs) to assist nursing home providers with development of effective cohorting plans. **(see Technical Assistance and Quality Improvement, Slide 28)**



Theme 4: Visitation (1/4)

Problem:

Visitation restrictions implemented to prevent COVID-19 transmission have protected the physical health of residents but also resulted in unintended harm. Residents are experiencing loneliness, anxiety, and depression due to prolonged separation from families and loved ones. Such measures also compromised the ability of families and guardians to validate resident wellbeing and safety and caused significant distress for families.

Principal Recommendation:

Emphasize that visitation is a vital resident right. Update and release consolidated, evidence-based guidance on safely increasing controlled, in-person visitation prior to Phase 3 reopening.

Recommended Action Steps:

Provide guidance on in-person visitation that immediately enables nursing homes to use emerging and established evidence to adjust protocols and safely increase in-person visitation by essential care partners, compassionate care visitors, and ombudsman. This CMS in-person visitation guidance should:

- Restate the existing right to visitation and clarify modifications to this right for each phase of the pandemic.
- Describe or restate minimum standards for testing, facial coverings and other PPE, temperature checks, physical distancing, visitor movement restrictions (e.g., separate visitor rooms, indoor/outdoor options, staggered visitation schedules), post-visit disinfection, instructional signage, supervision and assistance from staff, and COVID-19+ visits.
- Outline how to adapt visitation policies based on local prevalence of COVID-19 internal and external to nursing homes.
- Encourage nursing homes to have residents designate an Essential Care Partner (ECP); when resident cannot, the durable power of attorney (DPOA) holder could serve as an ECP or appoint a loved one as an ECP.
- Include a revised, person-centered definition of compassionate care and criteria for assessing when compassionate care and extended end-of-life visitation is appropriate.
- Stress that Ombudsmen may visit residents and relay information to families and guardians prior to Phase 3 reopening.

CMS actions to date:

- Advised nursing homes to adopt restrictive visitation policies. (4)
- Expanded visitation guidelines in compassionate care and other situations. (15)
- Provided FAQ about visitation. (19)
- Provided ideas to help residents connect with their families. (14)
- Incorporated visitor entry protocols into the COVID-19 survey tool for nursing homes. (13)
- Advised on Phase 2 and 3 visitation. (15)

Theme 4: Visitation (2/4)

Problem:

Virtual visitation is frequently an insufficient substitute to address resident needs as limitations related to equipment and internet availability; resident, family, and/or staff unfamiliarity with proper equipment use and functionality; and differing physical abilities may prevent successful implementation.

Principal Recommendation:

Update and release consolidated, evidence-based guidance on effectively planning for and implementing virtual visitation tools and techniques.

Recommended Action Steps:

- Provide guidance on virtual visitation that specifies evidence-based protocols for acquiring, using, and sharing technology and communicative devices (e.g., cell phones, tablets, web-cams, web applications/platforms) to safely facilitate virtual visitation. This CMS virtual visitation guidance should:
 - Emphasize that when a resident has the capability to use such technology independently or with minimal assistance, it should be permanently issued to them, just as residents used to have with landlines.
 - Link residents, families, and staff with learning resources about various technology tools.
 - Include information on accessing and utilizing low-cost, creative methods for maintaining two-way contact between residents and their loved ones (e.g., messages through windows, Jitterbug flip phone, postcards). (M)
- Continue to facilitate the sharing of ideas about virtual visitation options among nursing homes.
- Encourage state agencies to approve applications to use civil money penalty (CMP) funds for the purpose of providing communicative devices for virtual visitation. (M)

CMS actions to date:

- Provided FAQ about visitation. (19)
- Provided ideas to help residents connect with their families. (14)
- Notified state survey agencies that Civil Money Penalty (CMP) reinvestment funds may be used for programs that provide residents with adaptive communicative technologies for virtual visits. (13)

Theme 4: Visitation (3/4)

Problem:

The extent of unintended harm to residents (e.g., loneliness, anxiety, and depression) due to prolonged separation from families and loved ones has not been adequately assessed; additionally, nursing home staff have under-prioritized routine daily activities, exacerbating the unintended harm caused by overly restrictive visitation policies.

Principal Recommendation:

Provide resources to help nursing homes assess and improve the mental health and psychosocial well-being of residents during and after the pandemic.

Recommended Action Steps:

- Develop and distribute a mental health supplement for the comprehensive resident assessment instrument (RAI) required at 42 C.F.R. § 483.10 to help nursing homes assess and improve the psychosocial well-being of residents exhibiting a mental health status change. The supplement should:
 - Include assessment items separate from the current RAI questions on mood and behavior that would specifically identify when a resident is suffering emotionally due to isolation and lack of family contact due to restricted visitation
 - Include adaptation options so nursing homes can tailor to enhance their current resident assessments and meet unique needs of residents (M)
 - Include instruction for implementation by staff with training in behavioral health (P)
 - Inform resident care, recognizing that residents continue to have the right to shape their own care plans
- Monitor a subset of data generated from mental health supplement use and resultant care changes to assess impact; then consider formally integrating this mental health supplement into the RAI. **Note:** *Some Commission members feel this action step is logical and important; others do not.*
- Issue guidance that promotes regular socialization within facilities and outside of resident rooms; prohibits unnecessary isolation within resident rooms; and emphasizes the importance of routine daily activities (e.g., showering and personal hygiene, communal meals, meditation, exercise).
- Issue guidance for accessing and integrating telehealth mental health services for nursing home residents.
- Provide training at no cost to direct care providers on trauma-informed care.
- Amend 42 CFR § 483.10 to include reference to compassionate care under the residents' rights provision and define contingencies for emergencies.

Theme 4: Visitation (4/4)

Problem:

CMS and its federal partners have issued directives and guidance pertaining to visitation during the COVID-19 pandemic that now exist in multiple documents, making it harder to track federal expectations of nursing homes and any evolving flexibility that has been provided.

Principal Recommendation:

Assess, streamline, and increase the accessibility of COVID-19-related directives, guidance, and resources on visitation into a single source.

Recommended Action Steps:

- Categorize CMS's COVID-19-related ideas, suggestions, guidance, FAQs, and directives to-date regarding visitation ("visitation information"). (M)
- Analyze visitation information released to date for accuracy and actionability. (M)
- Synthesize visitation information into single, user-friendly source.
- Add single, user-friendly visitation information source to dynamic multi-user interface (**see Data, Slide 32**) to enable nursing home staff to exchange updated information with CMS and its federal partners and make evidence-based decisions about visitation policies and procedures.
- Establish an operating procedure to ensure timely updates on visitation as new evidence emerges. (M)
- Regularly update single visitation source based on emerging evidence.
- Work with state and local authorities to harmonize federal, state, and local visitation guidance, ideally through single, user-friendly, dynamic multi-user interface (**see Data, Slide 32**).

CMS actions to date:

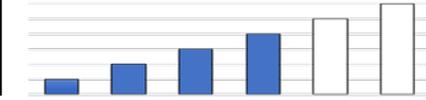
- Advised nursing homes to adopt restrictive visitation policies. (4)
- Expanded visitation guidelines in compassionate care and other situations. (15)
- Provided FAQ about visitation. (19)
- Provided ideas to help residents connect with their families. (14)
- Incorporated visitor entry protocols into the COVID-19 survey tool for nursing homes. (13)
- Advised on Phase 2 and 3 visitation. (15)

Theme 5: Communication

Relates to Objectives



Scale of Public Input



Problem:

Knowledge about COVID-19 (e.g., incidence, prevalence, virulence, symptoms, prevention, control, and treatment) is rapidly evolving. Keeping nursing home residents and their loved ones informed about the most up-to-date information on COVID-19, related protocols, and policies is a significant challenge.

Principal Recommendation:

Increase specificity and expand breadth of guidance on communications between nursing homes, residents, and families.

Recommended Action Steps:

- Provide standardized templates (e.g., for progress notes, email blasts, newsletters, bulletins, town hall discussion guides) for issuing regular COVID-19 updates that nursing homes can tailor to the literacy and cultural needs of recipients, including residents, essential care partners, resident representatives, family members, loved ones, and advocates.
- Define the type of information that nursing homes are expected to communicate (e.g., cohorting plan if a resident or staff member tests COVID-19 positive; transfer and discharge rights during phases of an emergency; visitation and/or connection options; screening/testing protocols and policies; COVID-19 cases and deaths).
- Define time-sensitivity of key communication messages (e.g., messages about transfers, discharge, hospitalization). (M)
- Require an individualized communication plan as part of each nursing home resident's individual care plan that include preferred mode (e.g., recordings, letters, phone, video, in-person) and frequency (e.g., weekly) of communications; between whom (e.g., residents, providers, loved ones; one-on-one, small groups, or large groups); and action steps for missed communications.
- Assess and advise nursing homes how federal COVID-19 relief funds can support nursing homes' adoption of multi-media communication systems (i.e., involving text SMS, phone, email, virtual townhalls, websites, applications, cameras).
- Amend federal requirements for nursing homes to create adoption protocols of multi-media communication systems. (M)
- Consider long-term regulations requiring nursing homes to integrate these updated communications methods.

CMS actions to date:

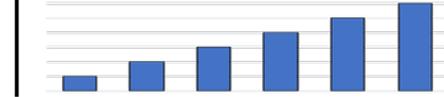
- Released guidance to nursing homes on alternative means of communication about visitation restrictions including signage at entrances/exits, letters, emails, phone calls, and recorded messages for receiving calls. (4)
- Released the Toolkit for State Actions to Mitigate COVID-19 Prevalence in Nursing Homes including examples of communications practices across all states. (14)

Theme 6: Workforce Ecosystem (1/7)

Relates to Objectives



Scale of Public Input



Problem:

Nursing home workforce ecosystem (education, recruitment, training, and retention) challenges are some of the key systemic failures at the root of the COVID-19 nursing home crisis. Specifically, low wages, high resident-to-staff ratios, pressure to deliver care for residents with complex needs under difficult conditions, and a dearth of systemic support significantly contribute to gaps in care for nursing home residents during the COVID-19 pandemic.

Principal Recommendation:

Address nursing home workforce hazard pay; assess and leverage emergency nursing home surge support options; and emphasize minimum care standards.

Recommended Action Steps:

- Assess federal COVID-19 relief funds for hazard pay options; have nursing homes access and distribute hazard pay.
- Continue Hospital Without Walls and Temporary Expansion Sites to flex hospital staff to nursing homes. (P)
- Assess and adapt existing predictive analytics platforms to anticipate hotspots and nursing home workforce surge needs.
- With FEMA and State Departments of Health, update existing emergency management plans to reflect emerging data.
- Work with state governments to update interstate compact language for public health emergencies to specifically include licensed and certified individuals, such as CNAs, to encourage the development of a hotspot staffing pool that can be used to ensure sufficient staff is available for surge support.
- Consider long-term guidance and regulations requiring nursing homes to integrate minimum care standards of hours of care per resident per day. Commission a study to establish an evidence-based standard for specific minimum care requirements during times of normal and emergency operations.
- Recommend that nursing homes incorporate increased break/recuperation time as well as time for proper PPE donning and doffing for direct care providers in emergency management planning.
- Assess engagement of medical directors in nursing home emergency management planning and execution.

CMS actions to date:

- With HRSA, has provided \$4.9 billion in CARES Act funding to support skilled nursing facilities.
 - With CDC, developed guidelines for healthcare facilities to address potential staffing shortfalls.
 - With HHS, enabled additional \$5B through CARES Act to build skills and enhance response, including enhanced infection control. Funding can be used to hire additional staff, implement infection control “mentorship” programs.
- (23)

Theme 6: Workforce Ecosystem (2/7)

Problem:

Certified Nursing Assistants (CNAs) spend more time with nursing home residents—including residents with additional COVID-19 care needs—as compared to other members of the nursing home workforce, yet they earn the lowest wages among direct care providers and receive few to any benefits. Moreover, the COVID-19 pandemic has disrupted CNA training critical for reinforcing the nursing home workforce, leading to serious CNA workforce deficits.

Principal Recommendations:

Issue guidance for on-the-job CNA training, testing, and certification; track all CNAs via a central registry; and catalyze interest in the CNA profession through diverse recruitment vehicles.

Recommended Action Steps:

- Permit nursing homes to hire less experienced personnel; provide them with on-the-job, developmentally-appropriate, culturally mindful CNA training, testing, and certification using current state standards and testing for nursing assistance certification; and require them to work under supervision upon completion of their on-the-job training and testing.
- Assess federal COVID-19 relief funds for on-the-job CNA training options; have nursing homes access these funds.
- With academia, monitor on-the-job programs for CNAs and their subsequent performance to verify effectiveness (e.g., standard of care, retention rates, continued education) and to accurately track workforce growth. (M)
- Include content and relevant links related to CNA careers and certification in the administration’s “Find Something New” campaign website. (M)
- In partnership with CNA professional associations (e.g., National Association of Health Care Assistants), develop and implement a National CNA Community of Excellence recruitment campaign.
- Develop a public-private partnership with relevant industry partners and academia to promote and amplify the CNA Community of Excellence campaign.

CMS actions to date

- Waived the requirements at 42 CFR 483.35(d) – except for the competency requirement under 42 CFR 483.35(d)(1)(i) – to assist facilities in addressing potential staffing shortages with the pandemic. (7, 23a)

Theme 6: Workforce Ecosystem (3/7)

Problem:

Emerging evidence indicates an increased risk of COVID-19 infection of direct care providers who work across multiple nursing homes. A preliminary analysis from CDC concluded that direct care providers working across multiple nursing homes — along with direct care providers continuing to work while sick — helped to hasten the spread of COVID-19. However, systemic workforce ecosystem problems prevent wholesale prohibition of multi-facility employment.

Principal Recommendation:

Provide guidance grounded in maximizing equity and preventing employee burnout that allows nursing home workforce members to continue to work in multiple nursing homes while adhering to infection prevention and control practices.

Recommended Action Steps:

- Distribute guidance for direct care staffing assignment patterns that require multi-facility direct care providers to work only with residents testing negative for COVID-19 or only with residents testing positive for COVID-19 across nursing homes within a given week (M). This guidance should include:
 - A recommendation that multi-facility direct care providers must be tested (diagnostic and serological) before rotating from serving residents with COVID-19 infection to serving residents without COVID-19 infection
 - A recommendation that nursing homes enable multi-facility direct care providers who test positive for COVID-19 to adequately quarantine before rotating from serving residents with COVID-19 infection to serving residents without COVID-19 infection
 - A recommendation that direct care providers work at no more than two nursing homes during the pandemic to allow for accurate contact tracing and monitoring
- Assess federal COVID-19 relief funds for paid leave options to support direct care providers during quarantine.
- Work with professional associations and organizations representing nursing homes and/or their staff to catalyze adoption of evidence-based, equitable assignment patterns by nursing home administrators and direct care providers. (M)
- Develop long-term regulations requiring integration of multi-facility direct care staffing assignment patterns into emergency planning.

CMS actions to date:

- With CDC, issued guidance that encourages direct care providers to tell facilities if they have had exposure to COVID-19 cases in other facilities. (8)

Theme 6: Workforce Ecosystem (4/7)

Problem:

SARS-CoV-2 manifests itself in sudden clinical changes that require astute triage, assessment, intervention, and stabilization and/or transfer of the resident to a higher level of care. These capabilities fall within the scope of practice of a registered nurse (RN); however, RNs are insufficiently present in nursing homes, especially during overnight hours, leaving LPNs and CNAs to complete tasks that may fall beyond their scope of practice.

Principal Recommendation:

Leverage funding and encourage the use of regional health system resources in partnership with state and local authorities to provide 24/7 RN staffing resources at nursing homes in the event of a positive COVID-19 test within that facility.

Recommended Action Steps:

- Support 24/7 RN staff augmentation in nursing homes with COVID-19 incidence among residents.
- Monitor and evaluate mortality and transfer rates of residents who have tested COVID-19 positive when an RN has been consistently present during their care.
- Commission a study to establish an evidence-based standard for specific, competency-based care requirements during times of normal and emergency operations.

CMS actions to date:

- Waived requirements in 42 CFR 483.30(e)(4) related to the delegation of certain tasks
physicians must provide personally; allows delegation of these tasks to a physician assistant, nurse practitioner, or clinical nurse specialist.
(23a)

Theme 6: Workforce Ecosystem (5/7)

Problem:

While the current regulation for an infection preventionist in a nursing home requires facilities to designate a minimally-qualified infection preventionist, the requirement is insufficient to meet the infection control and prevention demands of the current COVID-19 pandemic. Specifically, there are few recommendations included about training and licensure requirements. Moreover, this position is not financially supplemented, so the position is traditionally assigned to a supervisor, nursing manager, or provider as an added rather than a core responsibility.

Principal Recommendations:

- Identify and immediately leverage certified infection preventionists to support nursing homes' infection prevention needs.
- Professionalize infection prevention positions in nursing homes by updating regulations at 42 CFR § 483.80 so more fully qualified infection preventionists are available to serve in nursing homes.

Recommended Action Steps:

- Create a national registry of certified infection preventionists to provide immediate assistance to nursing homes without dedicated infection prevention support. Leverage infection preventionist resources from FEMA, the National Guard, the Public Health Service Corps, infection prevention recruiting companies, and infection prevention professional organizations (e.g., APIC and/or SHEA).
- Utilize training programs to provide a standardized, required, regularly-updated training curriculum and certification for infection preventionists in nursing homes at no cost to nursing homes. Established programs to consider:
 - Center for Disease Control and Epidemiology's Nursing Home Infection Preventionist Training Course
 - Association for Professionals in Infection Control's EPI in Long-Term Care Certificate Program, EPI Intensive Certificate Program, CIC Certification Preparation, Basics of Infection Prevention and Control for Non-Clinicians
 - Society for Healthcare Epidemiology of America's Podcast Series: Infection Control in Long-Term Care Facilities, SHEA/CDC Outbreak Response Training Program
 - Certification Board of Infection Control and Epidemiology Certified in Infection Control process
 - American Healthcare Association Infection Preventionist Specialized Training

CMS actions to date:

- With CDC, developed and released nursing home infection preventionist training courses (6)
- Mandated that all nursing homes have at least a part-time infection preventionist under 42 CFR § 483.80 (23)

Theme 6: Workforce Ecosystem (6/7)

Problem:

Workforce members with expertise in infection prevention and control competency development are not sufficiently utilized in nursing homes. When utilized, nursing homes may use external vendors/ staffing agencies with fewer insights into local nursing home context. This underutilization and insufficient integration has yielded knowledge and skills deficits among the workforce, especially related to emerging evidence about COVID-19 infection mitigation. Maintaining updated standards of care requires dedicated, onsite education and infection prevention professionals. This is a critical workforce problem that has caused serious infection prevention and control challenges throughout the pandemic.

Principal Recommendations:

Require nursing homes to employ infection preventionist(s) with educator duties and assess clinical evidence to establish an FTE: bed ratio, including considerations for Health Professional Shortage Areas (HPSAs).

Recommended Action Steps:

- Require infection prevention educators (“IP Educators”) to provide and document competency-driven, experiential training on core practice; crisis standards of care, including fit testing of N-95 masks and PPE donning and doffing; and recovery; and regularly assess competency achievement of all direct and contract staff (e.g., administrators, nurses, CNAs, environmental services, maintenance, food service, and ancillary staff).
- Provide templates for IP Educators to track staff infection prevention onboarding, training, and competency achievement.
- With CDC, develop for and distribute to IP Educators competency and self-efficacy measurements for proper PPE usage.
- Endorse individual competency assessment and achievement at an 80% threshold or higher.
- With state health departments, encourage collaborative site visits by infection control and prevention experts.
- With state and local authorities, develop partnerships with acute care/academic facilities to share simulation resources.
- Encourage state agencies to approve applications to use civil money penalty (CMP) funds for training costs (M).
- Include in Quality Assurance and Performance Improvement (QAPI) programs audits of IP education provision and participation and related IP emergency management protocols (M).

CMS actions to date:

- With CDC, developed and released nursing home infection preventionist training courses (6)
- Mandated that all nursing homes have at least a part-time infection preventionist under 42 CFR § 483.80 (23)

Theme 6: Workforce Ecosystem (7/7)

Problem:

Workforce ecosystem (education, recruitment, training, retention) challenges are notably longstanding, but have been exacerbated by the pandemic. Efforts to address workforce ecosystem challenges have been delayed, further jeopardizing an already fragile nursing home system. In addition to low pay and limited benefits, lack of educational support (e.g., limited assistance in progressing into LPN/RN training), insufficient competency standards, low-to-no exposure to geriatrics in formal education programs, and limited opportunities for professional advancement (e.g., no clinical ladder or lattice) limit the potential of the emerging workforce required to stabilize the nursing home system.

Principal Recommendations:

- Convene a Long-Term Care (LTC) Workforce Commission and/or Advisory Board to assess, advise on, and provide independent oversight for modernization of workforce ecosystem. (M)
- Work with federal, state, local, public, private, and academic partners to catalyze overhaul of workforce ecosystem.

Recommended Action Steps:

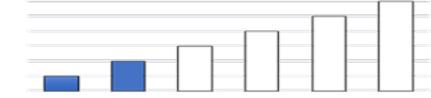
- Develop a charter and criteria to identify potential stakeholders to participate in the LTC Workforce Commission and/or Advisory Board. (M)
- Identify and work to achieve funding mechanisms that defer/reimburse CNA and LPN education costs after 3+ years of service in nursing homes.
- Establish a competitive grant program and/or national scholarship to fund entry into practice education for aspiring CNAs.
- With CDC and OSHA, identify core competencies for long-term care direct care providers; use to develop and/or update national training programs and standards (e.g., Nurse Aid National Training and Competency Evaluation Program).
- Work with the ANA, NAHCA, trade schools, universities, and state certification/licensure authorities to modify RN, LPN, and CNA clinical training standards for certification and licensure to include a clinical rotation in geriatrics in a long-term care setting to supplement staffing and provide immersion into geriatric care.
- With professional nursing associations and organizations, develop a meaningful national clinical ladder and lattice for long-term direct care providers—including CNAs, LPNs, and RNs—that includes access to career advancement opportunities and improved compensation.

Theme 7: Technical Assistance and Quality Improvement

Relates to Objectives



Scale of Public Input



Problem:

Technical assistance and quality improvement support have not been sufficiently available to nursing homes during the pandemic. While Quality Improvement Organizations (QIOs) provide asynchronous toolkits, information guides, and online learning options, nursing homes need proactive, tailored, timely, on-the-ground support in emergency management, infection prevention and control, and workforce capability development.

Principal Recommendation:

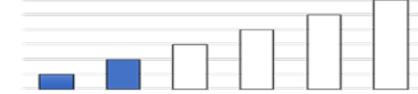
Identify and work to achieve funding mechanisms for—or reprioritize activities of—technical assistance and other contractors to increase the availability of collaborative, on-site, data-driven support prior to, during, and after a COVID-19 outbreak.

Recommended Action Steps:

- Redirect, prepare, and coordinate in partnership with regional strike teams Quality Improvement Network (QIN)-QIOs and other technical assistance contractors to provide on-the-ground technical assistance with organizational diagnosis, strategic direction, organizational resilience, resource prioritization, emergency management assistance, data management assistance, and workforce capability development in infection prevention and control, trauma-informed care, person-centered and person-directed care, visitation, and family communications and engagement.
- Research and provide exemplars of federal and regional strike teams.
- Support QIN-QIO technical assistance work with nursing homes and reinforce a cultural of learning by grounding information about citations and penalties in QAPI methodologies.
- Create and distribute an organizational-level Quality Assurance & Performance Improvement (QAPI) tool on how to effectively respond to COVID-19.
- Encourage nursing homes to use QAPI tools, data, and methodologies to improve their performance.
- Provide instruction to state surveyors on the Focused Infection Control (FIC) rules and survey process, including information about when surveyors should provide nursing homes with immediate feedback.

CMS actions to date:

- Announced the deployment of QIN-QIO resources to hotspots. (21)
- With CDC and OASH, deployed Federal Task Force Strike Teams for onsite infection control technical assistance and education to nursing homes experiencing COVID-19 outbreaks. (23)



Theme 8: Facilities (1/2)

Problem:

The physical environment in many nursing homes is not optimally designed to limit spread of transmissible diseases. Fundamental design changes are costly and may take longer to implement but may be necessary due to the prolonged risks to residents from COVID and to position facilities to manage future epidemics.

Principal Recommendations:

- Identify and share with nursing homes short-term facility design enhancements to address immediate pandemic-related risks that can be implemented at minimal cost.
- Establish a collaborative national forum to identify and share best practices and recommendations; facilitate real-time learning on how to best use existing physical spaces.
- Collaboratively establish long-term priorities and seek appropriate funding streams for nursing homes to redesign and/or strengthen facilities against infectious diseases. (M)

Recommended Action Steps:

- Close information gaps on how best to modify the physical plant by gathering best practices and issuing guidance. Examples of design enhancements:
 - Resident rooms: The ability to physically separate residents is greatly enhanced when rooms are occupied by only a single resident.
 - HVAC and air flow: modification and upgrades to HVAC systems further harden the infrastructure and potentially limit transmission.

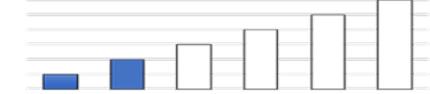
CMS actions to date:

- With CDC: Recommended identifying space in nursing homes that could be dedicated to preventing and controlling COVID-19 (Updated June 25)

Theme 8: Facilities (2/2)

Recommended Action Steps:

- Work with CDC to supplement CDC guidance with guidelines for the manipulation of HVAC systems that can reduce risk of transmission by:
 - Adjusting existing systems to support infection control (e.g. creating negative pressure, replacing filters)
 - Supplementing systems with equipment that can further purify air (e.g. air ionization, air scrubbers)
 - Setting standards for HVAC system performance as part of the long-term plan to upgrade systems and redesign nursing homes
- Encourage nursing homes to shift residents to single occupancy rooms for facilities that can accommodate this approach without detrimental reduction in census. Examine changes to the CMS reimbursement that would promote single occupancy (temporarily during pandemic and long-term).
- Establish a task force jointly led by industry, safety and consumer organizations to identify long term priorities for elder care in the United States with emphasis on the redesign, retrofitting, and reconfiguration of nursing homes to be resilient to infectious disease threats. (M) Topics to be considered include, but are not limited to:
 - The ability to separate wings for cohorting
 - Separate entrances and exits
 - Separate areas for staff and restrooms
 - Separate areas to put on and remove PPE
 - UV systems for decontamination
 - HVAC upgrades and retrofitting
 - Design considerations that take resident quality of life into consideration
- Consider a public-private partnership that issues a challenge for nursing home redesign. (M)



Theme 9: Nursing Home Data (1/3)

Problem:

Nursing homes' burden to report COVID-19 data to the federal government is not being sufficiently offset by the resulting benefit provided to nursing home residents, families, staff, and other stakeholders.

Principal Recommendation:

Improve COVID-19 data element standardization and data collection while identifying specific actions that CMS and federal partners will take in response to changes in key COVID-19 data indicators based on data reported by nursing homes.

Recommended Action Steps:

- Work with CDC to improve existing data elements and incorporate additional elements into the NHSN dataset that are essential for improved clinical outcomes and quality care delivery such as data on diagnostic test turnaround time, infection-control measures, staffing information, and housekeeping services.
- Capture and identify actions responding to the experiences, perspectives, and other specific issues of nursing home residents, families and staff through data related to demographics, visitation, satisfaction, quality of life, depression, and basic behavioral needs – such as ensuring residents have access to a phone.
- Partner with state and local authorities to develop threshold criteria for key nursing home data indicators (positive COVID-19 test results, deaths, low PPE supplies, staffing details) that will trigger responses by CMS along with state and federal partners (M).
- Leverage actionable nursing home equipment and supplies data reported to NHSN to assist with coordination of available resources and support for screening, testing, cohorting, training, and equipment needs at a national level.
- Provide clear guidance regarding the use of nursing home data to support facilities in a capability-enhancement manner while recognizing the need for enforcement of quality and safety standards.
- Require nursing homes to retrospectively report data on COVID-19 cases and deaths that occurred prior to the reporting requirements established in the May 2020 Interim Final Rule. *Note: Some Commission members feel this action step is logical and important; others do not. Note: CMS has stated publicly that it lacks legal authority to require this.*

CMS actions to date:

- With CDC, refining and creating more specificity for certain COVID-19 NHSN data elements.
- With CDC and OASH, provided staff for Task Force Strike Teams to provide technical assistance and training to certain nursing homes, in response to data that they reported to CDC indicating increases in COVID-19 cases. (23)
- Based on data reported, share list of nursing homes with increased cases each week to assist states in targeting support. (23)

Theme 9: Nursing Home Data (2/3)

Problem:

Information about the COVID-19 pandemic that is relevant to nursing homes has been inconsistent and scattered across multiple locations, making it difficult to find relevant, trustworthy, up-to-date data and guidance. Although the situation continues to rapidly evolve and some initial efforts have been made to consolidate information, a more cohesive approach to data collection and information dissemination is needed.

Principal Recommendation:

Develop a single, bidirectional application to serve as a central interface for nursing home data collection and information dissemination that includes essential COVID-19 guidance, statistics, and outcomes.

Recommended Action Steps:

- Collaborate with health IT resource and nursing home data providers to define and prioritize features and capabilities of the single, bidirectional application (M).
- Develop a secure method for nursing homes to enter new data and correct previously submitted data.
- Provide dynamic, real-time, mobile-friendly, HIPAA-compliant, and actionable feedback reports to nursing homes and federal partners based on the data entered or queried. The reporting elements should include, but are not limited to, clinical and performance metrics, resource utilization, survey responses, inspection data, and information related to the well-being of residents.
- Integrate a COVID-19 toolkit into the application to include an interactive map of states with the current applicable metrics, mandates, and guidance.

CMS actions to date:

- Established the COVID-19 Nursing Home Data website, which provides access to the COVID-19 Public File containing data reported by nursing homes to CDC's NHSN system, along with related resources and statistics. (10), (13), (26)
- Published actions taken in response to COVID-19 on the CMS website. (26)
- Indicated to the Commission at its final convening that work on a new user interface has been initiated.

Theme 9: Nursing Home Data (3/3)

Problem:

The lack of consistent nursing home data communication standards has hindered data management and data sharing between providers and payers, delayed effective care delivery, and resulted in poor data integration across care settings.

Principal Recommendation:

Enhance health information technology (HIT) interoperability to facilitate better communication, improve quality measurement standards, and coordinate integration of nursing home data with data from other health organizations.

Recommended Action Steps:

- Partner with ONC to develop interoperability and communication standards to integrate nursing home data with data from other health organizations, as demonstrated by ONC's Health IT Certification Program in the EHR market (M).
- Incentivize nursing homes to adopt health information technology to standardize data collection, transmission, and management to support health information exchange and access to comprehensive electronic health records by care providers across settings.
- Promote interoperability standards across nursing homes.
- Partner with state and local authorities to assess data needs and leverage data assets.
- Foster collaboration, data transparency, and information-sharing across health organizations and information technology vendors. **Note:** *Some Commission members feel strongly that if nursing homes are encouraged to contribute to data transparency, CMS should ensure protection of the facilities and healthcare providers through federal protections.*

CMS actions to date:

- Worked with states to survey nursing homes for compliance with 42 CFR 483.80 and CDC guidance, requiring nursing homes to notify state or local health department about residents or staff with suspected or confirmed COVID-19. (11)
- Used the NHSN to collect standardized COVID-19 data from nursing homes through new reporting requirements. (13)

CMS Actions to Date Reference List (still being validated; updated through 8/11)

- (1) [Initial Action to Prepare Healthcare Facilities](#) (February 6, 2020)
- (2) [Screening of entrants into nursing homes](#) (March 4, 2020)
- (3) [The use of PPE](#) (March 10, 2020)
- (4) [Restriction of staff and visitors](#) (March 13, 2020)
- (5) [Inspections and immediate jeopardy](#) (March 23, 2020)
- (6) [COVID-19 Survey for Nursing Homes Webinar Series](#) (March 23, 2020)
- (7) [Hospitals / laboratories can test for COVID-19](#) (March 30, 2020)
- (8) [Infection control responsibilities](#) (April 2, 2020)
- (8a) [Emergency Declaration Blanket Waivers](#) (April 9, 2020) (same as 23)
- (9) [Payment for COVID-19 testing doubles](#) (April 15, 2020)
- (10) [Nursing homes must report cases to residents/families](#) (April 19, 2020)
- (11) [Notification of Confirmed COVID-19 ... Residents/Staff](#) (April 19, 2020)
- (12) [Independent COVID-19 Commission](#) (April 30, 2020)
- (13) [Details to State Survey Agency directors](#) (May 6, 2020)
- (14) [COVID-19 toolkit for Nursing Homes](#) (May 13, 2020)
- (15) [Guidance on the reopening of nursing homes](#) and [related FAQs](#) (May 18, 2020)
- (16) [COVID-19 survey activities](#) (June 1, 2020)
- (17) [COVID-19 nursing home results from inspections](#) (June 4, 2020)
- (18) [Coronavirus Commission membership](#) (June 19, 2020)
- (19) [FAQs on nursing home visitation](#) (June 23, 2020)
- (20) [The end of the emergency blanket waiver](#) (June 25, 2020)
- (21) [Assistance from QIOs to hotspot nursing homes](#) (July 10, 2020)
- (22) [Rapid point-of-care diagnostic devices and tests](#) (July 14, 2020)
- (23) [New resources to protect nursing home residents](#) (July 22, 2020)
- (23a) [Emergency Declaration Blanket Waivers](#) (July 28, 2020)
- (24) [Reimbursement for counseling isolated residents](#) (July 30, 2020)
- (25) [CMS Flexibilities to Fight COVID-19](#) (July 30, 2020)
- (26) [COVID-19 Nursing Home Data](#) (Aug. 2, 2020)
- (27) [Nursing Home Data - Point of Care Device Allocation](#) (Aug.6, 2020)

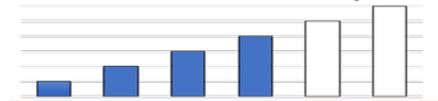
How to Read These Slides

Relates to Objectives



Highlighted squares indicate recommendations alignment to Commission objectives

Scale of Public Input



Highlighted bars indicate the approximate volume of public input received

Problem:

This area contains the problem(s) identified by the Commission for each of the topic areas/themes

Principal Recommendation(s):

This area outlines the Commission recommendation(s) to address the identified problem(s), at times enhanced by MITRE based on subsequent research and/or by public input.

Recommended Action Steps:

This area contains specific action steps for CMS to address the recommendation(s) above, with a focus on chronological actionable steps, at times enhanced by MITRE based on subsequent research and/or by public input.

CMS actions to date:

This area outlines CMS's actions to date relevant to the theme. In some cases, the area may also mention actions by other federal partners.

Numbers in parentheses refer to specific CMS action source citations on Slide 34

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