

Implementation and Enforcement of Quality and Safety in Long-Term Care

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SUMMARY. To understand how long-term care facilities, which less than 1% of the U.S. population lives in, became the source of more than 35% of COVID-19 deaths, you have to look beyond the vulnerability of the residents and examine how these facilities manage their employees and are regulated. Throughout the pandemic, grim reports consistently identified inadequate staffing, lack of effective infectious disease control and prevention, and poor emergency planning, as all factors that contributed to the death toll among residents and workers. In an effort to curb infection rates, federal emergency laws were passed, including the first universal paid sick leave law, and billions of federal government dollars were distributed to these facilities. In addition, the CDC Advisory Committee on Immunization Practices recommended targeting the limited vaccine doses to long-term care facilities first, in Phase 1a, which most states followed. However, these federal efforts failed to reach many of the intended constituents due to inequities around race, age, gender, socio-economic, and citizenship status. This Chapter provides recommendations on how to improve upon implementation of these federal efforts so that they are optimally and universally applied for a more resilient and equitable long-term care system.

Introduction

As the pandemic spread across the country, long-term care facilities struggled to prevent and contain outbreaks. While some challenges receded with greater precautions and better coordination between levels of government, a growing political and public outcry of dissatisfaction continues around quality of care and safety oversight. These issues were discussed in Chapter 19 in *Assessing Legal Responses to COVID-19: Volume I*.

The Chapter in Volume I highlighted three major missteps around staffing, infectious disease control and prevention, and emergency planning, then recommended strengthened legislation with regulatory oversight and enforcement. This Chapter provides an update on these missteps and offers a detailed analysis of how some of the laws that were passed with the specific intent to curtail COVID-19 infection rates were not universally implemented due to long-standing inequities. This Chapter concludes with recommendations to adopt at the federal, state, and local levels to address these inequities and improve long-term care going forward.

Updates Staffing

There are approximately 1.2 million direct care workers in long-term care; these include nurses, certified nursing assistants, and

personal care aides (Denny-Brown, et al., 2020). These workers are predominantly recent immigrants, women of color, and women with little education who earn low wages, with the average worker earning less than \$30,000 annually. In order to earn enough of an income to support themselves and their families, many of these workers are employed at multiple long-term care facilities and in-home health care (Milczarek-Desai & Sklar, 2021).

When COVID-19 started to spread throughout the country, the combination of working in different long-term care settings and the inability to take paid sick leave led to alarming consequences. Specifically, nearly half of COVID-19 infections in long-term care facilities have been traced to staff who work in multiple facilities and who engage in “presenteeism,” meaning they continue to work even after being exposed to or falling ill from COVID-19 (Chen et al., 2020). Presenteeism occurred despite the federal Families First Coronavirus Response Act (FFCRA), which required 14 days of paid sick leave for COVID-19 related reasons. This troubling finding highlights how essential it is for long-term care reform efforts to begin with better support for direct care workers, including mandating adequate staff-to-resident ratios, higher wages, and access to benefits, including paid sick leave.

Throughout the pandemic, direct care workers voiced complaints of unsafe working conditions and pressure to work while unwell, which were largely ignored. The refusal by legislators, regulators,

and industry leaders to address these concerns may have contributed to negative consequences in curtailing the spread of COVID-19, leading to extensive vaccine hesitancy among direct care workers and widespread staff vacancies in long-term care facilities.

In regard to access to vaccines, as many as half of direct care workers report vaccine hesitancy across the country. Recruiting and retaining direct care workers was difficult prior to the pandemic, and this need is expected to grow with an increasingly older population. While there is a federal law that requires minimum staffing levels, the Nursing Home Reform Law of 1987, and 41 states have passed higher staffing standards than this federal law, experts claim the ratios still fail to adequately protect older residents (Harrington et al., 2016). COVID-19 has also contributed to the growing need for well-trained staff given the high rates of delirium, cognitive dysfunction, and neurological damage being reported among older, COVID-19 survivors (Liotta, et al., 2020). Treatment for these ailments requires regular human interaction and rehabilitation, which mean time-intensive efforts by direct care workers, in order for these survivors to recover as completely as possible.

In order for federal and state efforts, such as paid sick leave legislation and vaccine distribution to effectively reach these intended direct worker constituents, these efforts must be bolstered by a long-term care system that workers can trust and feel a sense of safety.

Infectious disease control and prevention

Complaints from direct care workers in long-term care regarding workplace safety were largely dismissed by the Occupational Safety and Health Administration (OSHA), which did not execute legally binding regulations and failed to investigate the vast majority of complaints. There are current federal regulations to protect employees from hazardous conditions under the General Duty Clause, which during the pandemic could authorize the use of PPE. Under this clause, OSHA could have issued a directive requiring employers to comply with CDC guidelines for PPE and other safety measures, but it did not do so. Furthermore, OSHA's enforcement was minimal, with only a handful of onsite inspections conducted in response to thousands of complaints from direct care workers.

As the death toll rose over this past year in long-term care settings, so followed a great deal of industry resources focused on pushing through legal immunity to nursing homes. At present, COVID-19 legal immunity or shields have passed in over half the states. A central argument of industry groups requesting immunity is the national shortage around PPE and testing kits that limits their ability to control the spread of COVID-19 in facilities. However, even as PPE, testing, and now vaccines have become more widely available, this new immunity shield may continue longer than intended and hide misconduct unrelated to COVID-19. Furthermore, the pandemic has resulted in a substantial reduction in onsite inspections from regulators, which makes this immunity all the more concerning for ensuring minimum standards of care (Sklar & Terry, 2020).

Data and enforcement

The U.S. Department of Health and Human Services, Office of Inspector General (OIG) conducted a study to assess the sufficiency of Centers for Medicare and Medicaid Services (CMS) oversight of skilled nursing facilities (SNF) or nursing homes, which include approximately 15,500 facilities that have been certified by Medicare as 'skilled' (Grimm, 2020). There are an additional 28,000 assisted living centers that are also considered long-term care facilities, but they mainly provide custodial care beds and do not receive the same level of regulatory oversight and reimbursement from CMS.

OIG examined the number of infection control and complaint onsite surveys conducted from March 23 to May 30, 2020 at SNFs. This report found a decrease in overall inspections and wide variation among the states. Specifically, there was a 22% drop in SNFs receiving an onsite survey, and some states, including Arizona, reported that no surveys were conducted onsite at any nursing homes. Also, very few deficiencies were found nationwide suggesting that even the onsite inspections that were conducted may not have been thorough.

OIG concludes its report by recommending for CMS to work with SNFs to overcome PPE and staffing challenges. Facilities that receive CMS funding must comply with Conditions of Participation, which establish standards for quality of care metrics, including staffing, which CMS monitors and rates on a five-star system (Conditions of Participation, 2020). In theory, such monitoring should lead to data-driven regulation, where poorly performing facilities could be identified and improved.

Additionally, more comprehensive data could lead to more targeted federal and state funding efforts. For example, in May 2020, HHS distributed \$4.9 billion to SNFs based solely on the number of beds, and did not include variables, such as PPE and staffing shortages. In August 2020, another \$5 billion was announced for distribution. This HHS package included an incentive-based program with performance metrics to reward SNFs that have maintained a safe environment, but it is unclear whether this latest round of funds improved the level of care for higher risk SNFs that may have overall lower performance outcomes.

By contrast, The Quality Care for Nursing Home Residents and Workers During Covid-19 Act that was introduced on May 5, 2020, (Quality Care for Nursing Home Residents, 2020) specifically proposes to increase regulatory inspections with stricter protocols and distribution of funds tied to improving the level of care. Ultimately, more funding alone or only rewarding high performers may have a limited impact compared to linking dollars where they can be of the most use to improve quality and safety.

Lastly, there continues to be calls for better data: timely, accurate, reliable, and including race demographics about COVID-19 cases across long-term care settings. CMS released an interim final rule in May 2020 that required SNFs to submit weekly updates to CMS and CDC about confirmed and suspected COVID-19 infections and deaths at their facilities, PPE supplies, and staffing shortages (85 Fed. Reg. 27550, 2020). The rule did not include a requirement to

report demographic data related to COVID-19 cases and deaths, and there is currently no published data on the race of SNFs residents and workers by facility (Gebeloff et al., 2020).

Emergency planning and accountability

One of the more concerning missteps was when some governors issued executive orders to transfer recovering COVID-19 patients to long-term care facilities in order to free up intensive care unit beds. However, some of these facilities lacked sufficient PPE, testing kits, adequate staffing, and ability to isolate residents, which likely contributed to subsequent outbreaks.

For example, Governor Cuomo issued this controversial order in New York on March 25, 2020, then reversed it on May 10, 2020, claiming the long-term care facilities should not have admitted these patients if they couldn't isolate them. However, this runs counter to the order which states, "no resident shall be denied re-admission or admission to the [long-term care facility] solely based on confirmed or suspected COVID-19" (Graham, 2020). If a resident was not critically ill, it was unclear how a facility could deny admissions. Clearly, a more coordinated effort between the different levels of government and health care settings is essential to protect the public and minimize harm during a public health emergency.

Addressing Inequities in Implementation of Paid Sick Leave Laws

The prior Sections describe the treatment of direct care workers in long-term care, which highlight the racial, gender, and economic inequalities they experience, despite their essential role in caring for older Americans. This Section examines why so many direct care workers were unable to access paid sick leave during the pandemic even with federal, state, and local legislation requiring paid sick leave.

When female workers became ill with COVID-19 many did not take sick leave. First, many simply did not know they had a right to paid sick leave under the FFCRA. Second, they may not have been eligible because of their status as independent contractors rather than employees. Third, many may have failed to request sick leave for fear of retaliation, including loss of employment. Lastly, many feared their employer might expose them or co-habiting family members to deportation.

While the FFCRA is a milestone, there are more than 40 paid sick leave laws in cities, counties, and states nationwide. Even if FFCRA didn't apply to a direct care worker because of their employment status as an independent contractor, some of these other paid sick leave laws may have applied because they are based solely on hours worked. It is essential to understand how paid sick leave laws can be made more accessible to the constituents, such as direct care workers, that they are most intended to support.

How to Make Paid Sick Leave Work as Intended

First, these laws need to be enforced. Nearly all paid sick leave law violations require federal or state labor agency intervention. These agencies, however, often lack adequate resources to investigate and hold employers accountable should they retaliate against workers.

Second, most of these agencies are highly centralized and are unlikely to conduct effective outreach to immigrant communities, so both employers and employees are often unaware of paid sick leave laws. Some pioneering examples of state and local governments reducing barriers include posting guidance online in multiple languages about paid sick leave and conducting tele-town halls to help workers and employers understand their respective paid sick time rights and obligations. 🌟

Recommendations for Action

As of February 2021, there have been more than 160,000 COVID-19 deaths from long-term care residents and staff. Their exposure to COVID-19 largely occurred due to staff working in multiple facilities when they were unwell and many of these same workers are now experiencing vaccine hesitancy. These recommendations attempt to mitigate the continued spread of COVID-19 as well as support a long-term care system that is incentivized by laws and regulations to prioritize the health and safety of residents and staff.

An urgent direct step that can be taken immediately to help reduce COVID-19 exposure in long-term care facilities is to extend paid sick leave legislation at the federal and state levels, and also include local community outreach and enforcement. If this legislation could be tied to paid leave for recovery from the COVID-19 vaccines, then that may also help reduce vaccine hesitancy.

Federal government:

- Congress should pass an updated Nursing Home Reform Law that aligns with experts' recommendations for adequate staff-to-resident ratios.
- Congress should consider the proposed Quality Care for Nursing Home Residents and Workers During COVID-19 Act of 2020 in the next coronavirus relief package or similar legislation to better link funding with quality and safety, including minimum staffing levels and paid sick leave based on hours worked.
- CMS should expand the metrics it collects on nursing homes to include race demographic data.

State governments:

- State legislators should pass or amend legislation that requires minimum staffing levels at all long-term care facilities to align with expert recommendations.
- States should pass or amend paid sick leave laws to ensure there is funding for conducting outreach to immigrant communities and other vulnerable population groups, funding for enforcement, and retaliation protection.
- States should pass legislation that requires all licensed long-term care providers to provide a minimum wage to direct care workers that align with expert recommendations.

Local governments:

- Cities and counties should pass or amend paid sick leave laws to ensure there is funding for conducting outreach to immigrant communities and other vulnerable population groups, funding for enforcement, and retaliation protection.



About the Author

Tara Sklar, JD, is Professor of Health Law and Director of the Health Law & Policy Program at the University of Arizona, where she launched and oversees multidisciplinary, online, graduate and undergraduate programs in health law. These programs include over twenty courses in Aging Law & Policy, Health Information Privacy & Data Security, Health Law for Health Professionals, and Regulatory Science. Sklar's research focuses on how laws and policies influence the health and well-being of older adults. Her work has appeared in the following peer reviewed journals: *New England Journal of Medicine*, *Journal of Empirical Legal Studies*, and *Jurimetrics*, among others.

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