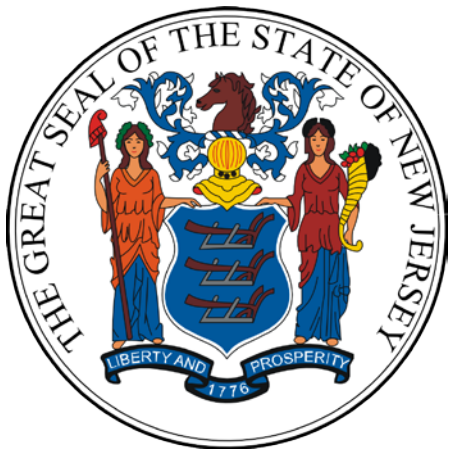




Recommendations to Strengthen the Resilience of New Jersey's Nursing Homes in the Wake of COVID-19

June 2, 2020



manatt

PROJECT BACKGROUND

Rapid Assessment of NJ's COVID-19 Response for LTC

Context

- In response to the growing impact of COVID-19 on nursing home residents and staff, in early May, the New Jersey Department of Health (DOH) engaged Manatt Health (Manatt) to undertake a rapid assessment of the state's COVID-19 response targeted toward the long-term care (LTC) system.
- Manatt was charged with providing the state with a set of actionable recommendations over the near-term and intermediate to longer-term aimed at improving the quality, resilience and safety of the state's LTC delivery system now and for the future.
- Over the three-week project, Manatt undertook a review of relevant literature, conducted a data review, evaluated national best practices and actions taken in other states, and conducted over fifty interviews with stakeholders from:
 - New Jersey state government
 - New Jersey associations
 - New Jersey labor representatives
 - New Jersey nursing homes
 - New Jersey consumer and advocacy groups
 - National experts
 - Other states
- ***Based on this assessment, this report presents a series of recommendations over the near-term (next 4 months) and intermediate to longer-term (5+ months) to:***
 - ***Strengthen emergency response capacity***
 - ***Stabilize facilities & bolster workforce***
 - ***Increase transparency & accountability***
 - ***Build a more resilient & higher quality LTC system***

Comment on Limitations

- This report was developed over a three-week period when the COVID-19 landscape in New Jersey was changing rapidly. The recommendations in this report are informed by the most up-to-date information at that point in time, but Manatt recognizes that week to week – and often day by day – there are new developments and information relating to the COVID-19 crisis.
- The primary focus of this report is skilled nursing facilities (SNFs), nursing facilities and special care nursing facilities (collectively referred to in this report as nursing homes) licensed by the state of New Jersey, rather than the full range of congregate care settings that operate in the state. Additional work may be done to identify which of these recommendations can be extended to those care settings. The term “LTC facilities” is used when recommendations apply to facilities beyond nursing homes.
- While this report is about nursing homes, the people who reside in nursing homes have diverse needs. They include people with both short- and long-term stays, and people with dementia, serious mental illness, traumatic brain injury and intellectual/developmental disabilities.
- Because this report was developed during statewide “stay-at-home” orders and while nursing home visitation was restricted, Manatt did not conduct any in-person visits to nursing homes. Instead, Manatt held video and telephonic calls with many stakeholders, including a sampling of facilities, as well as trade associations, labor representatives, consumer advocates and many others. In the future, in-person visits could further inform these recommendations.
- This report highlights a set of recommendations deemed to be high-impact actions that the State can take. It does not represent the full spectrum of actions and improvements that the state may want to consider. Many of the recommendations in this report are interdependent.
- Importantly, implementation of many of these recommendations will require further planning, and statutory or regulatory changes, and many of these recommendations will require additional funding.

CONTEXT

Throughout COVID-19, we have seen unsung heroes who have stepped up to an extraordinary degree—including many government leaders and staff and nursing home administrators. Most notably, the front-line staff in nursing homes, who placed their own health and the health of their families at risk, deserve our recognition and gratitude.

Despite efforts to manage spread of coronavirus in NJ and elsewhere, COVID-19 fed on and exposed weaknesses in our health care system, perhaps most notably in our nursing homes.

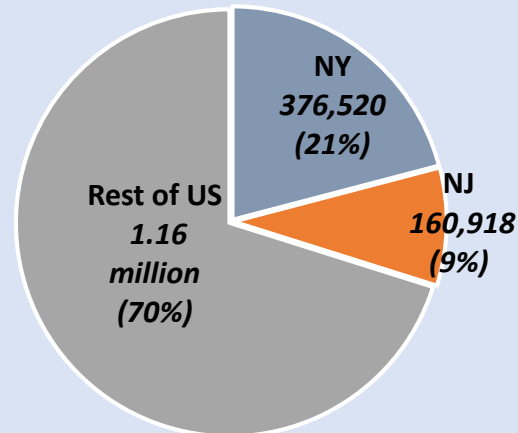
The Situation and Challenges Are Not Unique to New Jersey

- As the outbreak unfolded, the situation was rapidly changing on the ground, which impacted both the federal and state responses.
- Similar to other states, New Jersey's initial preparedness coordination was more focused on external threats to the state, with an emphasis on responding to the risk from international travel.
- New Jersey quickly pivoted to focusing on the health care delivery system response focus, though—as was true in many states—with greater emphasis on inpatient hospital surge capacity planning and support. The focus on hospitals prompted the prioritization of the distribution of supplies, personal protective equipment (PPE) and other resources to that sector.
- DOH released a series of guidance directed toward LTC facilities beginning on March 3* and began to distribute some PPE to nursing homes later in the month.

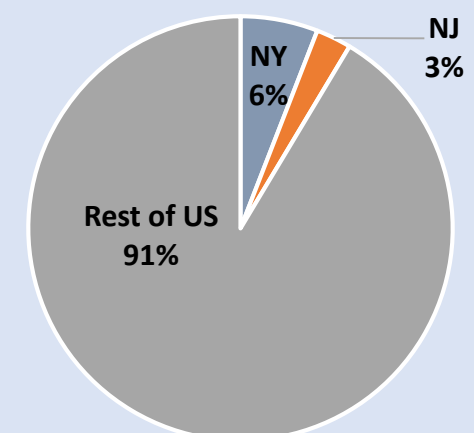
New Jersey Was Hit Early and Hard

- New Jersey had its first diagnosed COVID-19 case on March 4; at that time, testing was scarce and the testing and spread-risk was focused on symptomatic people. Along with the broader New York City metropolitan area, cases rapidly increased in March.
- Likely due to its proximity to New York City and density, New Jersey ranks second nationally behind New York in cases (160,918) and deaths (11,721) as of June 2.

COVID-19 Cases

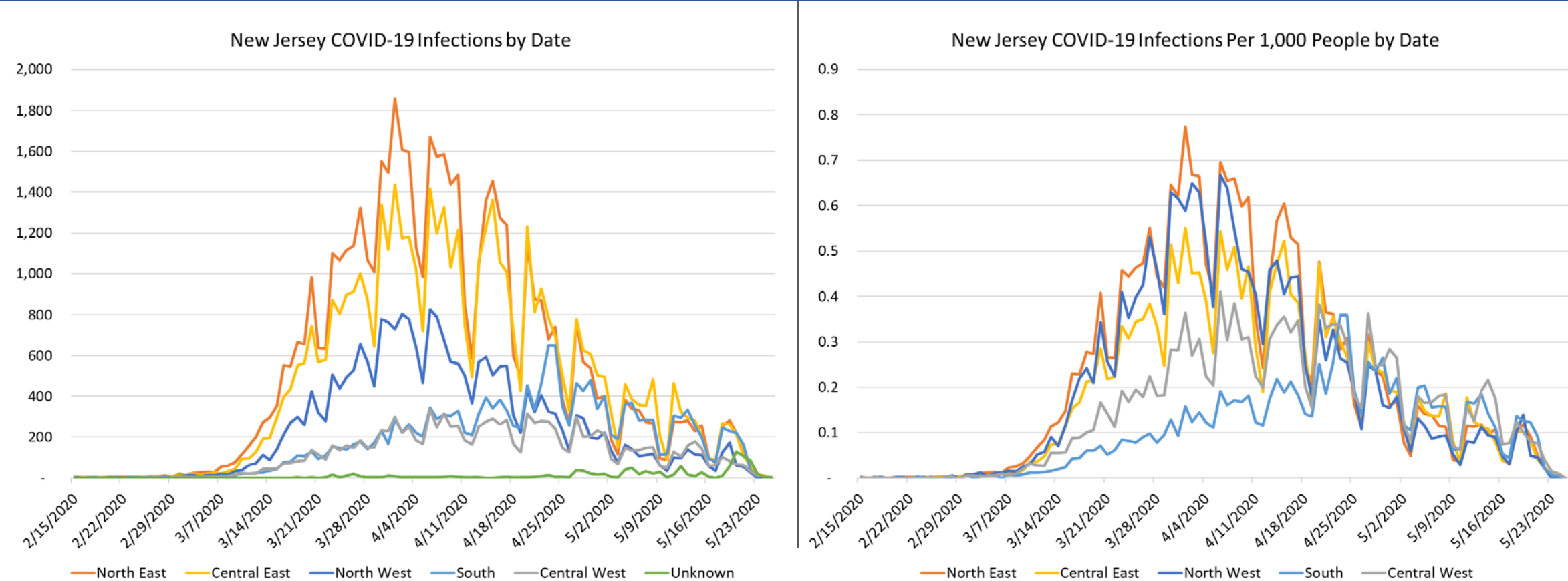


Share of US Population



How Did We Get Here? (cont.)

New Jersey’s outbreak peaked in late March through early April, with a substantial portion of the population affected.



Source: Manatt analysis of COVID-19 infection and death data file received from NJ DOH received on May 26, 2020; U.S. Census, Population Reference Bureau, “Annual Estimates of the Resident Population for Counties in New Jersey: July 1, 2019”, data.census.gov

Residents of nursing homes were particularly vulnerable.

Nursing homes are hotspots for infectious disease outbreaks and were quickly hit by COVID-19

- The state's [Wanaque Center](#) for Nursing and Rehabilitation had a serious, widely covered viral outbreak among a particularly vulnerable, specialized community of children using ventilators just over a year ago.
- The [Life Care Center](#) in Kirkland, Washington, was the center of the first major U.S. COVID-19 outbreak, and nursing homes in Europe were ravaged by the virus.

*Nursing homes are
congregate settings
that are the home for
people prone to
infection with
weakened capacities
to fight back.*

Certain characteristics of New Jersey nursing homes—which are not unique to the State—put them at particularly high risk of an outbreak

- New Jersey has many old facilities, many with 3- and 4-bedded rooms.
- A large percentage of nursing homes in New Jersey have documented infection control deficiencies and citations.
- Nursing homes are staffed by workers who are also subject to community spread; many of whom came from communities with large outbreaks.

Most tragically, high community spread in New Jersey brought COVID-19 into New Jersey's nursing homes.

Why It Matters: Protecting our Families, Neighbors and Caretakers

People living in nursing homes are our mothers and fathers, our sisters and brothers, our aunts and uncles, our grandparents and great-grandparents, our former teachers, our veterans and our neighbors.

People Living in Nursing Homes

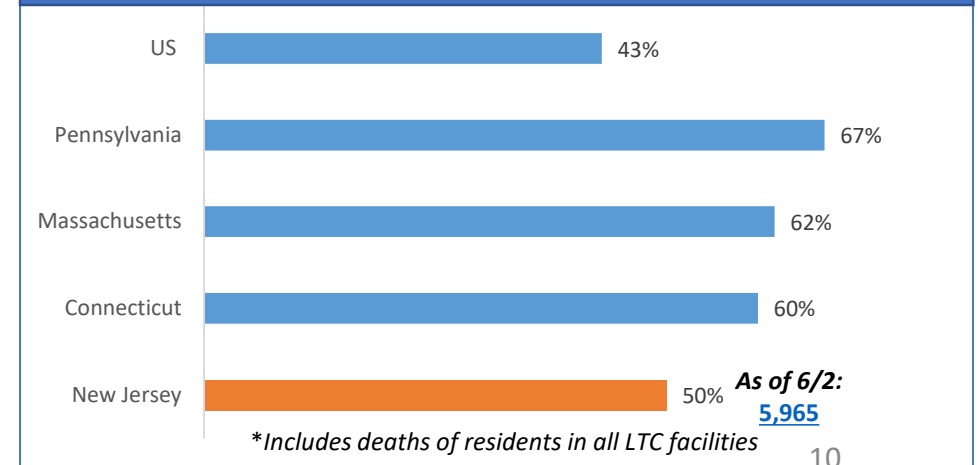
- On an average day, over 45,000 New [Jerseyans](#)—approximately 0.5% of the state population—are residing in a nursing home.
- People living in nursing homes have their own preferences and must have agency in decisions that impact their homes and lives.
- Nursing home residents are among our most vulnerable community members. Many are over 85 years of age, and they may be disabled, medically frail or have mental impairments.
- Nursing homes provide crucial medical, skilled nursing and rehabilitative care for both short stays (such as on a post-operative basis) and LTC. People receiving short-term v. long-term care in nursing homes have very different needs.
- In New Jersey, two or three individuals often share nursing home rooms. There is a growing movement in New Jersey and throughout the country to modernize nursing homes to make them more home-like and less institutional.
- People living in nursing homes long term are often without means and/or have spent down most of their resources before turning to Medicaid, which is the primary payer for nursing home services.

New Jersey Nursing Home Demographics 2018

	Medicaid	Medicare	Other	Total
Average Daily Census	26,570	6,823	12,455	45,847
Average Length of Stay (days)	365	31	81	102

As of February 2020, about 20,500 Medicaid beneficiaries residing in nursing homes were [enrolled](#) in managed long term services and supports (MLTSS) and 6,500 were in fee-for-service.

Share of COVID-19 Deaths in Nursing Homes and Assisted Living Facilities as of 5/22



Why It Matters: Protecting our Families, Neighbors and Caretakers *cont.*

Nursing home staff working on the front lines, who continue to place their own health and the health of their families at risk throughout COVID-19, deserve support and protection.

Nursing Home Staff

- 54,361 staff work in New Jersey nursing homes, including nursing staff, food, cleaning, and administrative staff.
- Certified nursing assistants (CNAs) and licensed practical nurses (LPNs) provide most of the care in nursing homes. CNAs are the backbone of the staff and provide close to 90% of direct care, including bathing, lifting, toileting and assistance with daily activities, to New Jersey’s nursing home residents.
- Chronic staffing shortages of CNAs and LPNs put additional pressure on overworked staff.
- Further, due to the low wages, many nursing home staff nationally and in New Jersey work more than one job, sometimes across multiple nursing homes, sometimes shifting between hospitals and nursing homes or other part-time jobs.
 - In New Jersey, CNAs make an average of \$15/hour and LPNs make an average of \$27.65/hour.
- Some facilities pay higher wages in lieu of benefit packages; some facilities pay lower wages with benefits. 13% of workers have no health insurance.
- The overwhelming majority of the New Jersey nursing home direct care workers are women who are racial or ethnic minorities. Half are immigrants.
- CNAs have experienced the same childcare and family care obligations during the pandemic that are exacerbated when schools and child care are closed and family members are ill as everyone else – but like all frontline responders, they cannot work from home.

Spotlight on NJ Direct Care Workforce

- CNAs: 15,606
- LPNs: 5,603
- RNs: 4,900
- Women: 91%
- Racial or Ethnic Minorities: 84%
 - Black or African American: 61%
 - Hispanic or Latino: 14%
 - Asian or Pacific Islander: 7%
 - Other: 2%
- Immigrants: 50%

NJ LTC Workers’ COVID-19 Status as of June 2

Cases	10,895
Deaths	107

COVID-19 didn't create the problem – it exacerbated the long-standing, underlying systemic issues affecting nursing home care in New Jersey.

Critical Themes

- Nursing homes **were largely underprepared for the threat of a widespread infection** and under-resourced due to long-standing staffing shortages or low staffing ratios. Many had previously been cited for infection control deficiencies.
- There was room for improvement in **bidirectional communications** between nursing homes and DOH. Lapses on both sides may have contributed to inconsistent compliance with DOH guidance.
- Nursing homes generally were **not adequately tied into the larger system of care** and typically do not have strong communications and consult relationships and protocols with emergency departments. Further, there is often poor communication between nursing homes and hospitals at the point of hospital admissions and discharges. In addition, there is a lack of interoperability between nursing home and hospital electronic health records.
- **Under-resourced state agencies** did not have sufficient staff to deploy to facilities and **conduct meaningful oversight** prior to COVID-19.
 - No LTC-focused **preparedness plan** was in place in the state prior to COVID-19 with **respect to PPE, staffing back up plans or communications from facilities** to hospitals or families.
 - Much of the oversight of nursing homes is **highly prescribed** by federal rules; the federal requirements are **rigid**, often resulting in **paper compliance and limited improvements**.
- New Jersey's LTC industry and its regulatory agencies were not equipped with **the technological systems or the practiced processes** to rapidly collect and share data in support of the state's public health response.

You cannot invent a system that works when a crisis hits; the system must already be in place.

Elements of a High-Functioning, Resilient LTC System

Key elements:

Person-Centered	Communication + Collaboration	High Quality, Safe Facilities	Aligned Regulatory Oversight + Support	Emergency Preparedness
- Meaningful choice, with access to supports to enable living at home/preferred residence as long as possible - Goals of care plans and ongoing dialogue - More home-like and non-institutional nursing homes - Resident empowerment and active engagement around wellness - Use of telehealth and consumer-convenient services and supports - Culture of caring and respect	- Regular communication among and between patients, families, employees, care delivery partners, facilities and regulators - Formal cross-agency collaboration centered on LTC - Clear bi-directional family/caregiver channels - Meaningful forums for stakeholders to provide input and to participate in industry-wide improvement - Culture of problem-solving	- Adequate staffing levels – both overall and by skill level - Enhanced wages and benefits to reduce turnover and moonlighting and ensure consistency - Modernized facilities with more single rooms, updated HVAC, broadband and IT infrastructure - Strong infection control policies and procedures. Access to clinical expertise; engaged clinical relationships - Culture of quality	- High degree of transparency across system - Sufficient staff, resources and expertise state-level - Real-time use of data to inform interventions, educate public and hold industry accountable - Meaningful consequences for consistently poor performance - Payment aligned with desired system outcomes - Culture of accountability	- Clear emergency plans at facility, regional and state levels and defined roles and responsibilities - Clear communications plan - Ongoing training and drills; learning system with access to technical assistance - Strong community relationships - Culture of safety

Critical enablers:

Strong sense of purpose, mission and value

Technology-enabled and data-driven

Viable financial model(s)

While COVID-19 has shone a light on the structural deficiencies in how we provide and fund LTC, it also presents an opportunity for meaningful change:

- LTC workers and facilities are on the frontline of the pandemic response.
- COVID-19 exposed weakness and vulnerabilities in the system that represent a tough—but not insurmountable—set of challenges.
- Stakeholders across New Jersey have mobilized to support their neighbors and have collaborated in new ways, demonstrating opportunities for greater alignment across the system.
- Policymakers and regulators have developed a clearer view of the key priorities for reform going forward.
- Recovery from this crisis should be a catalyst for change, bringing together policymakers, providers, community members and others to create a high-functioning, resilient LTC system.

Landscape Review

Although New Jersey has a wide range of congregate care settings, including assisted living facilities, veterans memorial homes, developmental centers, and group homes, this report focuses primarily on nursing homes.

<u>Spotlight on New Jersey Nursing Homes</u>	
Total number of nursing homes	370
For-profit ownership	74%
Non-profit ownership	23%
Government owned	3%
Average number of residents per day per nursing home	119
Bed occupancy rate	82%
Average number of beds per nursing home	145

Source: Manatt analysis of Nursing Home Compare data as of May 12th, 2020

Infection Control Deficiencies in Nursing Homes



Approximately one-third of nursing homes surveyed by New Jersey in 2017 were cited for an infection prevention and control deficiency.

Infection Prevention and Control Deficiencies Cited, by State, 2017			
State	Number of Surveyed Nursing Homes	Number With an Infection Prevention and Control Deficiency Cited	Percentage of Surveyed Nursing Homes With an Infection Prevention and Control Deficiency Cited
New Jersey	334	105	31.4%
Total Across U.S.	14,550	5,755	39.6%

Nursing Homes with Infection Prevention and Control Deficiencies Cited, by State, Aggregate of Surveys from 2013 through 2017					
State	Total Surveyed Nursing Homes 2013-2017	Nursing Homes With No Infection Prevention and Control Deficiencies Cited	Nursing Homes With Infection Prevention and Control Deficiencies Cited in Only One Year	Nursing Homes With Infection Prevention and Control Deficiencies Cited in Multiple Non-Consecutive Years	Nursing Homes With Infection Prevention and Control Deficiencies Cited in Multiple Consecutive Years
New Jersey	374	95 (25%)	133 (36%)	55 (15%)	91 (24%)
Total Across U.S.	16,266	2,967 (18%)	4,309 (26%)	2,563 (16%)	6,427 (40%)

Source: Infection Control Deficiencies Were Widespread and Persistent in Nursing Homes Prior to COVID-19 Pandemic, GAO. <https://www.gao.gov/assets/710/707111.pdf>

Distribution of COVID-19 Across New Jersey Nursing Homes: Early Observations

Manatt Health conducted an analysis of COVID-19 cases and deaths in New Jersey nursing homes reporting to CMS. These facilities were selected for in-depth review due to the availability of information regarding Star ratings, survey results, licensed beds, health deficiencies, ownership status and staffing. The facility data from CMS were cross-walked to the New Jersey COVID-19 dashboard for confirmed COVID-19 cases and deaths in LTC facilities as of May 22, 2020. **See Appendix for additional details.**

Key Takeaways

Based on available data, strong and consistent patterns between nursing home COVID-19 cases and deaths and potential predictive characteristics were not immediately evident. Early observations included:

- The Central East, Central West, and South regions had fewer COVID-19 cases per 1,000 people and fewer nursing home cases per licensed bed compared to the North East and North West; **in other words, with some exceptions, the intensity of COVID-19 cases in nursing homes largely mirrored their surrounding communities.**
- Larger nursing homes have not had a higher rate of confirmed COVID-19 cases or deaths on a per licensed bed basis than smaller nursing homes.
- For-profit and not-for-profit nursing homes have had similar rates of COVID-19 cases and deaths per licensed bed (additional in-depth analysis recommended); however, data were not available to consider for-profit and not-for-profit subgroups.
- An observed relationship has not been identified between the Centers for Medicare and Medicaid Services' (CMS) Nursing Home Compare overall Star rating or quality star ratings and total COVID-19 nursing home deaths per licensed bed in New Jersey. (Continuing evaluation is happening across the industry, including new reporting requirements for direct reporting to CMS, and these issues are anticipated to receive much scrutiny in the coming months.)
- Weak relationships – if any – have been observed between number of COVID-19 deaths per licensed bed and nursing home health and infection control deficiencies given available data.

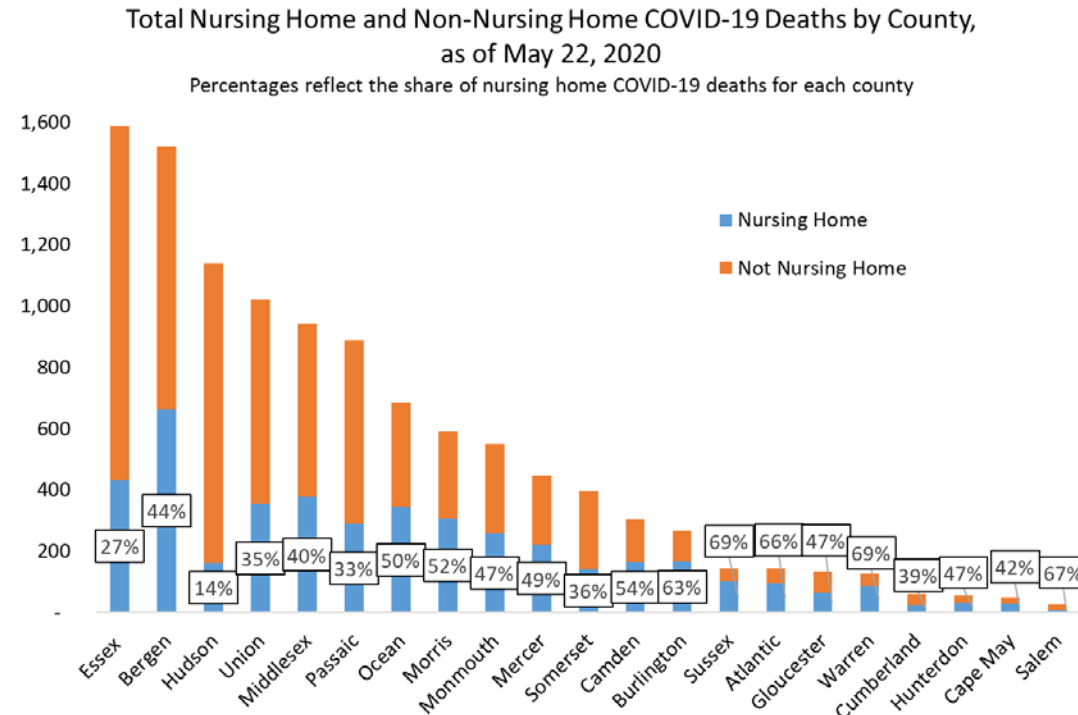
The early analytic results are based on Manatt's analysis of available data, including the sources listed below.

- Nursing Home Compare data (<https://www.medicare.gov/nursinghomecompare/search.html>) – accessed, May 12, 2020)
- U.S. Census data (<https://data.census.gov/cedsci/>) – accessed, May 12, 2020)
- New Jersey LTC COVID-19 infection and death data (<https://www.state.nj.us/health/healthfacilities/documents/LTCFacilitiesOutbreaksList.pdf>) – accessed, May 12, 2020)
- New Jersey COVID-19 dashboard data (https://www.nj.gov/health/cd/topics/covid2019_dashboard.shtml) – accessed, May 22, 2020)

Note: On June 1, 2020, CMS released a first tabulation of survey data from the Nursing Home COVID-19 Data Source: CDC National Healthcare Safety Network (NHSN). This data reflects data entered into the NHSN system by nursing homes as of May 24, 2020 and is anticipated to be updated on a weekly basis. CMS reports this initial data tabulation is incomplete; only approx. 80% of facilities reported by the deadline. CMS also notes that, as with any new reporting program, some of the data from their early submissions may be inaccurate as facilities learn a new system. Of note, facilities may opt to report cumulative data retrospectively back to January 1, 2020, though no facility is required to report prior to May 8, 2020. Therefore, some facilities may be reporting higher numbers of cases/deaths compared to other facilities, due to their retrospective reporting. The availability of testing may impact the number of confirmed COVID-19 cases facilities report. Deaths in this data set are only counted if they include a lab confirmation for COVID-19.

High Percentage of NJ COVID-19 Deaths Have Been in Nursing Homes

By county, the percentage of total COVID-19 deaths that has occurred among nursing home residents has ranged from 14% to 69%.



Notes: Chart presented for directional purposes only. Deaths reported by LTC facilities to DOH; deaths may not be lab confirmed. Total and nursing home-only deaths collected from separate data sources that may have differences in data collection, compilation, and presentation methodologies resulting in slight deviations in totals by date when compared. Nursing home deaths only includes COVID-19 deaths attributable to nursing home residents and nursing homes listed in the CMS Nursing Home Compare database. All other COVID-19 deaths, including nursing home staff deaths and those attributed to assisted living and non-Medicare/Medicaid certified nursing homes are counted as "not nursing home." Source: Manatt analysis of Nursing Home Compare data as of May 12th, 2020, U.S. Census data, Long Term Care Facility COVID-19 infections and deaths from New Jersey as of May 22, 2020: https://www.state.nj.us/health/healthfacilities/documents/LTC_Facilities_Outbreaks_List.pdf and the New Jersey COVID-19 dashboard https://www.nj.gov/health/cd/topics/covid2019_dashboard.shtml " as of May 22, 2020

Anecdotes From the Field: Responses Were Inconsistent During COVID-19

Nursing homes had to quickly adapt their everyday operations to respond to the challenges presented by COVID-19. In hindsight, some may have exacerbated outbreaks.

“ Some facilities with 3- and 4-bedded rooms moved patients closer together because they were so seriously short-staffed. Their intention was to improve safety and deploy workforce more strategically but in hindsight, it was the opposite of what should have happened. ”

“ A nursing home began to disseminate COVID-19 information to staff and residents/families, to screen visitors and test and train staff on hygiene procedures in the facilities in January. The nursing home also isolated residents and staff upon a positive test, and paid workers a bonuses to retain workforce. ”

“ A nursing home began lowering its daily census in February, restricting congregate meals, increased wages of nursing home staff and limited their ability to work at multiple facilities, stockpiled PPE and brought in a nurse educator on infection control. She did rounds with them to see how staff was using PPE and made suggestions on how they could improve their use of PPE. ”

“ A large, isolated facility operates van carpools to bring staff in from a large city in Northern New Jersey (which happens to be a high community outbreak region). Even if staff isolated and practiced good infection control in the facility, social distancing in large van carpools is impossible. ”

“ At the beginning of the crisis, the feelings among most staff were fear and panic. They weren't provided training on infection control and use of PPE, and guidance kept changing. Some employers were opting out of the paid sick leave made available under the federal emergency legislation. So people were going to work even if they were sick because they needed to get paid. Some facilities loosened their attendance policies, but some did not.” ”

Recommendations

Core Recommendations

Strengthen Emergency Response Capacity

Strengthen the ability to plan, coordinate and execute effective responses to the emergency and potential surges

1 Consolidate and Strengthen Response Through a Central LTC Emergency Operations Center

2 Implement “Reopening” Plan and Forward-Looking Testing Strategy

3 Implement Strategy for Resident & Family Communications

Stabilize Facilities & Bolster Workforce

Increase the responsibilities of and support for New Jersey’s nursing homes and their workers in the short and longer-term

4 Recognize, Stabilize & Resource the Workforce

5 Institute COVID-19 Relief Payments for Facilities & Review Rates

Increase Transparency & Accountability

Implement stronger mechanisms to ensure a greater degree of accountability and increase transparency through data and reporting

6 Institute New Procedures to Regulate and Monitor Facility Ownership

7 Improve Oversight of and Increase Penalties for Nursing Homes

8 Rationalize and Centralize LTC Data Collection and Processing

Build More Resilient & Higher Quality System

Implement structures for stronger collaboration and advance payment and delivery reforms, including increasing reliance on home- and community based services (HCBS)

9 Improve Safety and Quality Infrastructure in Nursing Homes

10 Strengthen State Agency Organization and Alignment Around LTC

11 Create Governor's Task Force on Transforming New Jersey’s LTC Delivery System

Note: Many of these recommendations are interrelated; the order of recommendations does not indicate relative priority.



Consolidate Response Effort Through a Central LTC Emergency Operations Center: Context

Context

- To manage reopening and potential future surges, New Jersey will need a **tightly managed, unified response and “true north” to coordinate resources and communications particularly** in light of a large fragmented LTC industry.
- New Jersey’s emergency management central command structure is widely seen as organized and effective. It is unique in its organization under the State Police, but like many states, it more frequently focuses on incident/hazard response and natural disasters, coordinating through a network of county offices and a large number of highly decentralized public health offices.
- In support of the COVID-19 response, New Jersey reactivated a **regional medical coordination center (MCC)** model, which has been effective in managing hospital capacity.
- However, in spite of an expanded emergency response focus on LTC facilities, there **are many moving parts and alternative mechanisms for nursing homes and other LTC facilities related to reporting, seeking supplies (PPE and testing equipment) and addressing urgent issues**. Facilities have varying capacities to absorb and appropriately respond to the information and direction.
- With sufficient resources, DOH could mount a **central infrastructure or capacity that coordinates all activity and communications for nursing homes** and LTC, which have proven to be the “eye of the storm” in the COVID-19 pandemic.

Examples From Other States

- **Delaware** activated its State Health Operations Center (SHOC), which provides command and control for all public health emergencies. SHOC operations include “Points of Dispensing,” alternate care sites, and a joint centrally located information center that includes workers from multiple state agencies.
- **Colorado’s** Unified Command Center launched a Residential Care Task Force which rapidly implemented actions to mitigate COVID-19 spread.



Consolidate Response Effort Through a Central LTC Emergency Operations Center: Recommendations

Near-Term Recommendations



- 1. Establish New Jersey Long-Term Care Emergency Operations Center (LTC EOC) as the centralized command and resource for LTC COVID-19 response efforts and communications.**
 - The LTC EOC would build on proven regional infrastructure and supplement (but not duplicate) and work in concert with the current statewide COVID-19 emergency response efforts, as led by the Coronavirus Task Force, and supported by the New Jersey State Police's Office of Emergency Management (OEM).
 - The LTC EOC would be led by DOH and staffed by DOH, Department of Human Services (DHS), or other agency staff (or through contract support) as determined by DOH and DHS leadership. The LTC EOC team could also include clinicians, public health experts, elder affairs and disability services representatives, emergency response/ New Jersey OEM representative(s), and other stakeholders as DOH deems appropriate.
 - The LTC EOC would have ongoing, direct communication mechanisms and feedback loops, including an advisory counsel, to obtain real-time input from facility owners and staff, unions, resident/family advocacy representatives, and experts in the needs of special populations, among other stakeholders, as appropriate.
 - In addition, the LTC EOC would have a DOH staff person as the designated liaison to the industry.
 - The LTC EOC would be charged with providing guidance to the State/OEM team to ensure that supplies are secured and distributed rationally, critical staffing shortages are identified and solutions developed, problems are quickly surfaced and addressed, the operational aspects of planned policies are vetted with industry and key stakeholders, and that policies and guidance are effectively communicated to all stakeholders in order to ensure coordination and effectiveness.

1 Consolidate Response Effort Through a Central LTC Emergency Operations Center: Recommendations

Near-Term Recommendations

- A dashboard could be developed (expanding on the current emergency data sources) to provide a real-time line of sight into on-the-ground challenges and emerging issue areas and to proactively, for example, where and when a facility may need more than 30-days of PPE on hand.
- In addition to coordinating resource distribution, the LTC EOC would develop additional state guidance and federal guidance and emerging best practices related to COVID-19-related infection control, symptom monitoring, use of telehealth and other. As with the resource distribution guidance, the operational aspects of planned state guidance—including guidance suggested in other recommendations—would be vetted with key stakeholders to ensure successful implementation.

2. Evaluate Regional Coordination Aligned with Hospital MCC Model

- New Jersey had a legacy regional medical coordination center (MCC) model* for disaster response (akin to the Federal Emergency Management Agency (FEMA) Medical Operations Coordination Cells ([MOCCs](#))) to help facilitate regional capacity coordination and communication across hospitals in the event of an emergency. DOH reactivated three regions to support the COVID-19 inpatient response. A similar structure would be beneficial for LTC facility coordination, but is more challenging to stand up.
- One option is to expand on the existing regional MCCs and pair hospitals with nursing homes for infectious disease and infection control consultation and emergency resource coordination, including potentially testing support as needed. This would require additional funding and should be discussed as a potential model with FEMA among others.

**New Jersey consolidated its MCC operations from five into one center in 2018.*



Design and Implement a “Reopening” Plan and Forward-Looking Testing Strategy for Nursing Homes: Context

Context

- Nursing homes support **short stay** (such as post-acute care rehabilitation) and **long stay** (residential) needs and are critical providers of **palliative care and end-of-life care** for many. Most of the short stays have stopped with the COVID-19 outbreak, but, as the health system resumes so-called elective cases, patients will require high-quality, safe nursing home services and New Jersey’s facilities will need to accept patient transfers.
- **The nursing home ecosystem relies on many individuals** from outside the facility, from medical providers, to therapists, social workers, faith-based leaders, and health plan care managers, as well as ancillary service providers. **Family and other visitors and volunteers are also essential**, providing social visits and supplemental support services, including feeding, bathing, dressing, personal care and other functions.
- In order to **“reopen”** nursing homes and resume normal operations, however, critical steps are needed to fully prepare for a possible second wave and/or isolated outbreaks and **protect residents and staff** to the fullest extent possible.
- **New Jersey will need to provide clear guidance, direction and protocols, including on testing and supplies, and facilities must act accordingly to ensure that nursing homes can safely reopen** to key providers such as hospice as well as visitors and new residents, that potential infections can be identified and interventions swiftly implemented, and that there are sufficient contingencies in place in the event of new crises. New Jersey has made progress in these areas, but additional work is necessary.

New Federal Guidance

- On May 18, the U.S. Department of Health and Human Services (HHS) issued nursing home reopening [guidance](#) for states focused on a phased approach:
 - Criteria for relaxing certain restrictions and mitigating risk of resurgence and factors to inform decision-making
 - Considerations allowing visitation and services
 - Recommendations for restoration of survey activities
- On May 19, the Centers for Disease Control and Prevention (CDC) updated and expanded its [guidance](#) for nursing homes, related to tiered requirements by phase, testing plans, and infection control.



Design and Implement a “Reopening” Plan and Forward-Looking Testing Strategy for Nursing Homes: Recommendations

Near-Term Recommendations

1. **Develop a plan and provide guidance for how New Jersey nursing homes can comply with and implement federal guidance on reopening.** Through the LTC EOC, seek and incorporate feedback from stakeholders including nursing homes, hospitals, and other providers on feasibility and clinical considerations.
 - The guidance should provide, as a condition of reopening, that every facility have the following:
 - Adequate isolation rooms/capabilities and the ability to cohort both staff and patients;
 - An adequate minimum supply of PPE and test kits; and
 - Sufficient staffing and a staffing contingency plan and appropriate staff training to carry out its responsibilities.
 - The guidance should define acceptable models of cohorting (e.g., single rooms, separate wings/floors), the staffing levels that must be in place, and how PPE and testing will be made available to facilities that are unable to obtain them on their own.
 - Implement a centralized FAQ resource, education sessions and focus groups to support nursing homes in implementing this guidance.
 - Require facilities to attest to meeting all requirements before opening their facility to new residents and others, including family members, and if – at any time after opening – the circumstances change, they are obligated to report any gaps that need to be addressed through the emergency center communications mechanism.
 - Do not permit hospitals to discharge patients to nursing homes unless such attestations are in place.
 - The LTC EOC, with support or “strike” teams, will regularly check in on facilities’ capacity to reopen or stay open, and where necessary, provide assistance to the facility during the public health emergency.
 - Plan for the changes in policy and operations that may be needed if the flexibilities currently authorized under federal 1135 waivers expire before future waves.

Examples From Other States

- [Maryland](#) has three types of statewide strike teams support nursing homes: testing teams (test and provide instruction on cohorting), assistance teams (assess equipment and supply needs, triage residents), and clinical teams (provide medical triage and stabilize residents in the nursing home to prevent transport to hospitals).
- [Pennsylvania](#) deployed a Medical Assistance Team to provide staffing support to facilities in need. The State also developed detailed [guidance on cohorting](#) in response to test results.
- [Minnesota](#) designated nearly a dozen LTC facilities as “COVID support sites.” Facilities must be vetted by the state to ensure they have adequate staffing, supplies and infection-control standards to accept COVID-19 patients, including the ability to cohort residents.



Design and Implement a “Reopening” Plan and Forward-Looking Testing Strategy for Nursing Homes: Recommendations (*cont.*)

Near-Term Recommendations

2. Back-up Plan for Patient Placement in Event of Regional Outbreak or Surge

- The state should be prepared to support and quickly stand up at least three regional hub facilities for COVID-positive patients who do not require hospitalization to manage capacity and centralize expertise in the event of future waves or case surges that overly tax the system’s capacity to manage care.
- The LTC EOC and facilities should regularly monitor current capacity and intervention or patient redirection needs.

3. Forward-Looking Comprehensive Testing Plan

- New Jersey issued a mandatory testing [Executive Directive](#) on May 12 for nursing home residents and staff, which will provide a baseline. The Executive Directive permits monetary penalties for non-compliant facilities; DOH should impose these penalties as appropriate once there are sufficient testing kits available.
- Going forward, New Jersey will need a practical, feasible and flexible forward-looking testing policy:

Capacity to evolve over time:

- Should account for both advances in saliva testing, point-of-care and serological testing and the ability to pivot to individualized testing over frequent broad testing at the appropriate time.
- Future testing policies should consider the risk of spread by group or setting, as well as the relationship to local infection rates, which will change over time.
- Should include a combination of symptom screening and testing for visitors with flexibilities for frequent visitors who were previously tested and attest to certain infection control protocols.
- In the event recurring testing is needed, the protocols should prioritize the least invasive, most expedient methods available.

Centralized supports should include:

- Clear guidance for nursing homes that are able to implement and manage a robust testing process in-house or with their own system resources and associated funding information.
- A mechanism by which nursing homes can partner with select “hub” hospitals, based on the regional coordination structure (as was successful in the Southern New Jersey testing pilot) or preferred vendors.
- A network of preferred labs.
- Capability to quickly stand up state/hospital-supported mobile testing units in the event of a surge.

Guidance on staff, supplies and funding:

- Facilities should provide on-site testing opportunity to staff.
- Protocols should be developed related to staff who work at multiple locations and communication of testing results.
- Support for overall funding and supplies should be developed through LTC EOC to ensure rational allocation; nursing homes should be prioritized for testing supplies.
- Long-term and ongoing reimbursement needs to be further worked out at state and federal levels.



Design and Implement a “Reopening” Plan and Forward-Looking Testing Strategy for Nursing Homes: Recommendations (*cont.*)

Near-Term Recommendations

4. Back-up Staffing Plan

- With ongoing testing, it is likely that staff – potentially on a rolling basis – will need to be quarantined or take sick leave due to exposure to the virus (and/or for asymptomatic staff to be moved to COVID-19 wings/units).
- Each nursing home must develop a staffing back up plan, using the LTC EOC communication mechanism to alert the state to staffing shortages. Options for ensuring adequate staffing will include a combination of (among others):
 - “Bridge teams” (which could be formed in collaboration with hospitals, for example) to provide immediate temporary support;
 - Staffing back up contracts negotiated by facilities, with encouragement to contract on a regional basis and potentially in partnership with hospitals to achieve advantages of scale;
 - National Guard deployments;
 - Improved operations of the “Call to Serve” (volunteer) registry to improve vetting of volunteers qualifications and willingness to volunteer in certain settings.
- Require nursing homes to report on staff quarantined or taking sick leaves to identify new or looming shortages.

Intermediate to Long Term Recommendations

- Given the financial challenges and costs faced by health care providers due to the pandemic, some nursing home operators in New Jersey may file for bankruptcy or indicate an inability to continue operations.
- New Jersey should plan for such economic distress scenarios and evaluate options for receivership, management support and other mechanisms to support distressed facility operators to ensure continuity of high-quality services to residents if needed.



Implement Strategy for Resident & Family Communications: Context

Context

- Restricting visitation at the peak of the COVID-19 pandemic was necessary to protect nursing home residents; however:
 - It **cut residents off** from regular communication with loved ones, and
 - It prevented family members from **playing a role in caring for residents and monitoring the day-to-day operations of nursing homes**.
- DOH has taken steps toward addressing these issues, such as issuing a directive to nursing homes in early April (in line with state statute and regulations) prior to related federal guidance to notify all residents and staff members of suspected or confirmed cases of COVID-19.
- Additional protocols and resources should be put in place to **ensure frequent and regular communications between families and residents and facility staff** during periods of restricted visitation.
- In addition, support is needed to ensure residents are able to leverage **telehealth** opportunities and ensure continuity of care.

Examples From Other States

- **New York** strongly encourages nursing homes to develop a communication protocol for family, loved ones and residents when visitation is suspended that includes notification of suspected cases of COVID-19 and regular updates.
- **Massachusetts** launched a family resource line that is staffed seven days a week from 9 a.m. to 5 p.m. Staffers coordinate with state agencies to find answers to callers' questions, in addition to directing them to the state's nursing home resource site.
- **Florida** is partnering with the Alzheimer's Association and other stakeholders to distribute tablets statewide and provide training to nursing home and assisted living facility residents to enable communication with family.



Implement Strategy for Resident & Family Communications: Recommendations

Near-Term Recommendations

- Develop **guidance establishing expectations for nursing homes' communications** with residents and staff, families, and other representatives, including Medicaid managed care plans and care managers, covering:
 - **Frequency** of communications between (1) nursing homes and families, and (2) residents and their families.
 - **Content** of communications, including updates on the resident, the facility, and COVID-19 cases.
- Disseminate guidance to residents, families, and representatives on the **process for elevating concerns** to nursing home staff, Medicaid managed care plans, and relevant branch of the state (e.g., DOH or LTC Ombudsman).
- Strengthen MLTSS contractual requirements for **care manager responsibilities** at times when visitation is restricted.
- Further publicize process for nursing homes to [request](#) up to \$3,000 to **purchase communicative technology** (e.g., iPads, Amazon Echo, etc.) paid for using civil monetary penalty funding pools.

Intermediate to Long Term Recommendations



- Require nursing homes to **dedicate a staff member to manage communications** across residents, their families, and other representatives, including supporting residents with using technology for personal calls and telemedicine.



Recognize, Stabilize & Resource the Workforce: Context

Context

- Nursing home staff face a high risk of **contracting and/or transmitting** COVID-19 while caring for vulnerable residents.
- Nursing home staff **earn close to minimum wage**, have **inconsistent access to health coverage and sick leave**¹ and are **often not recognized or valued as part of the health care workforce**, factors that contribute to chronic staffing shortages and turnover, and training gaps.
- Many nursing home staff **work across multiple facilities** to support their families.
- While some nursing homes in New Jersey have independently extended wage enhancements to staff during the emergency, the state **has not instituted wage pass-throughs or other forms of supplemental pay** to workers.
- **Wage enhancements can help mitigate the need for staff to continue to work across multiple facilities**, decreasing the risk of exposure for themselves and residents.

¹ Neither New Jersey's progressive paid sick leave policies (N.J. Stat. Ann. § 34:11D-8 (West)) nor the federal Families First Coronavirus Response Act provisions relating to sick leave extend to all nursing home workers

Examples From Other States

- **Illinois** nursing home workers secured a new contract that includes an additional \$2/hour for employees working during the COVID-19 stay-at-home order. The contract also increased base pay rate to at least \$15/hour and expanded sick leave.
- **Massachusetts** funded a \$1,000 signing bonus to workers who registered through its LTC staffing portal to work a minimum number of hours at a nursing facility. Eligible staffing types include: RN, LPN, CNA/Patient Care Tech, OT, OTA, PT, PTA, LICSW, and activities staff.



Recognize, Stabilize, & Resource the Workforce: Recommendations

Near-Term Recommendations



Ensure all nursing home staff have access to **paid sick leave**.

- Institute **wage enhancements** for staff who work a minimum number of hours in a single nursing home, now and for future COVID-19 waves (could be funded through Medicaid or Coronavirus Aid, Relief, and Economic Security (CARES) Act funding).

Intermediate to Longer-Term Recommendations



Work with legislature to create a workforce development and appropriations package to:

- Design and implement **minimum staffing ratios** for RNs, LPNs, and CNAs that are aligned with differential needs of nursing home residents (e.g., residents with dementia). Prohibit professional staff serving in administrative roles from counting toward these ratios.
- Establish a **wage floor and wage pass-throughs** for future Medicaid rate increases. Wage increases should be linked to expectations for additional training for workers to strengthen quality of care.
- Strengthen **training and certification requirements and opportunities**, including annual in-service education requirements to build skills and expand scopes of practice.
- Seek federal and state funding to develop a **direct care workforce career development program** focused on recruitment, training and career advancement.



Institute COVID-19 Relief Payments for Nursing Homes & Review Rates Going Forward: Context

Context

- To respond to COVID-19, nursing homes have additional costs related to **cleaning, facility reconfiguration, PPE, testing and staffing**, while they are **losing revenue** from the lack of rehabilitation stays after elective procedures. Nursing homes have a **short-term need** to fund these new costs to promote safety.
- To date, approximately one-third of states have **made COVID-19 relief payments to nursing homes** to offset increased costs and to ensure sufficient liquidity to maintain full operations; New Jersey has not done so.
- Medicaid is the largest payer for LTC services. While DHS has instituted multiple rate increases since fiscal year 2016, current **Medicaid rates do not anticipate wage increases and state-of-the-art equipment**, among other expenses.
- Some nursing homes across the country, however, **have generated large profits**.
 - For example, nationwide in 2016, for-profit SNFs had an average Medicare profit of 14%, with one-quarter of facilities having a profit of over 20.2%. However, Medicaid is the largest payer for nursing homes and individual facility potential profitability also depends in part on whether and to what extent the home serves Medicaid-covered residents.
 - These profits may represent funds that are **diverted** from the provision of care and facility upgrades. DOH and DHS have **limited insight** into how nursing homes are using their publicly-funded revenues.

Relevant Federal Guidance

- In March, CMS released a Disaster Relief State Plan Amendment template, permitting states to temporarily increase rates for services covered through Medicaid fee-for-service
- In mid-May, CMS released guidance to states on ways to effectuate temporary provider rate increases through Medicaid managed care.



Institute COVID-19 Relief Payments for Nursing Homes & Review Rates Going Forward: Recommendations

Near-Term Recommendations



- Rely on federal coronavirus relief and stimulus funding, including CARES Act funding, and/or Medicaid to provide temporary relief payments to nursing homes. Any new disbursements should net out previously received CARES Act funding. *(See Appendix for description of CARES Act funding.)*
- New Jersey may want to consider whether temporary relief payments should be tied to compliance with reporting and other requirements.

Examples From Other States

- **Connecticut** increased nursing home provider rates by 10% to cover:
 - Staff retention bonuses, overtime, and shift incentive payments
 - New costs related to screening visitors, PPE, and cleaning and housekeeping supplies
 - Other COVID-related costs
- **Massachusetts** temporarily enacted a 10% Medicaid rate increase for nursing homes to support additional staffing, infection control and supply costs. Facilities that create dedicated COVID-19 wings and units and follow necessary safety protocols are eligible for an additional 15% rate increase.



Institute COVID-19 Relief Payments for Nursing Homes & Review Rates Going Forward: Recommendations (*cont.*)

Intermediate to Longer-Term Recommendations

1. Review Rates and Link Any Increases to Quality and Safety

- Contract with a vendor to conduct a **rate study** to assess: (1) **sufficiency of Medicaid nursing home rates** to cover direct care and administrative costs (e.g., reporting); (2) the distribution of nursing home spend between direct care, administrative costs, and other expenses; (3) nursing home resident **acuity levels**; (4) potential to apply **acuity adjustments to rates**; and (5) rate implications of **staffing recommendations** in this report. Vendor should have experience working with at least 10 other states and/or health insurance carriers on health rating and have expertise on rates for nursing homes.
- If rate modifications are recommended, seek legislative authorization for increases. Require a portion of any rate increase be **passed through to nursing home workers**, similar to state legislation passed for personal care services, and **tie increases to quality and safety improvements**. For example, require facilities to:
 - **Meet new staffing level requirements**;
 - Have staff **participate in a state direct care workforce career development program**; or
 - Implement policies for **improved coordination with MLTSS and care managers**.
- Review DHS's multi-year Medicaid **value-based payment strategy**, including the Quality Incentive Payment Program, to ensure incentives **focus on key priorities for quality improvement** and consider whether incentives are enough of a "carrot" to impact behavior.

2. Create a Direct Care Ratio (DCR) Reporting and Rebate Requirement

- To ensure payments to nursing homes—including any increases—are used for resident care, seek legislative authorization to develop a **nursing home DCR**—similar to the medical-loss ratio (MLR) requirements that apply to insurance plans—that requires facilities to use no more than a certain percentage of revenues for administrative costs and profits. Insurance MLRs range from 80-89%. Set **DCR** based on historical cost reports and adjust as needed based on new financial reporting requirements.
 - **Audit cost reports and recover payments** in excess of the DCR requirements.
 - **Monitor performance** of nursing homes to inform adjustments to DCR.



Institute New Procedures to Regulate and Monitor Nursing Home Ownership: Context

Context

- Nationally and in New Jersey, the **ownership of facilities has become heavily for-profit and is frequently changing hands**. A facility may change ownership multiple times in a single week.
- For-profit facilities have opaque financials and can use complex ownership and management structures to **obscure the entities responsible for delivering care**, curtailing the ability of the state and residents to hold them accountable.
- **Rigorous change of ownership (CHOW) requirements are critical** for ensuring accountability and promoting quality and stability of the workforce. Current DOH processes fall short:
 - DOH currently collects information from anyone with a 10% director or indirect ownership interest; however, many states require the disclosure of anyone with a 5% (or less) interest.
 - CHOWs are not public, and DOH has not historically disapproved a CHOW.
 - Facilities that change ownership are not subject to any additional oversight or reporting following the change.
- The certificate of need (CON) process provides a more rigorous review of new facilities; however, **a loophole in the CON process allows new facilities to acquire previously approved but not utilized “paper beds”** from other owners.
 - Every five years, a facility may request approval of up to 10 beds or 10% of its licensed bed capacity, whichever is less, without CON approval. Some facilities never actually add the beds, but holds approval or gives approved beds to a “paper bed” broker. New owners can acquire “paper beds” (the beds acquired through the add-a-bed process but never used) through the CHOW process, allowing them to skip the CON process entirely.

Examples From Other States

- **Massachusetts** provides an opportunity for public input on any proposed CHOW or notice of intent to sell or close a SNF. Applicants must submit three years of projected profit and losses, and projected three years’ capital budget.
- **New York** requires a CON review process, including a public hearing, for CHOWs.



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Institute New Procedures to Regulate and Monitor Nursing Home Ownership: Recommendations

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Intermediate to Longer-Term Recommendations



Increase transparency in CHOWs.

- **Require disclosure of all direct and indirect owners** having any or a 5% or more (states vary in their approaches) ownership interest and all related parties that will be providing services to the facility.
- **Require a proposed budget** to be submitted with the CHOW application.
- **Publicly post** proposed CHOWs and solicit constituents' feedback.
- **Require closer scrutiny of quality** and compliance with MLR requirements in the 2-3 years following a CHOW; including annual licensure surveys.
- Impose a **waiting period** following a CHOW during which another CHOW cannot occur.
- **Do not approve CHOWs** when DOH has concerns regarding the prospective owner; instead, if necessary to protect residents, propose temporary receivership or solicit a temporary manager. To the extent permitted by law, DOH could have a standing contract with a vendor that can be triggered if the need arises.



Close loopholes that allow **significant changes without DOH oversight**.

- **Require prior approval** before allowing a facility to delegate facility management to a third party.
- Revise the regulation to clarify that all **beds added through the “add-a-bed” process solely be used by the facility and make these beds nontransferable**.



Improve Oversight of and Increase Penalties for Non-Compliant Facilities: Context

Context

- Survey and complaint processes are primary mechanisms for **protecting residents** who are unable to advocate for themselves.
- DOH's certification and survey and complaint investigatory arm has been historically **under-resourced and understaffed**.
 - DOH is **unable to perform all of its CMS-mandated activities**. It has 4,000 backlogged complaints, 700 of which are high priority due to the nature of the complaint. Some complaints are over two years old.
- DOH performs CMS-required facility surveys timely; however, there is broad agreement that the CMS survey process is flawed. For instance, nursing homes are subject to the same survey intensity **regardless of historical compliance**, and while the surveys are unannounced, **facilities are often able to predict when they will occur and ramp up staffing and alter existing procedures** to produce better outcomes.
- CMS has authority over the sanctions and penalties imposed for CMS survey deficiencies. Penalties are frequently reduced by CMS through the appeals process. Even when financial penalties are imposed, they do not deter bad behavior. Nationally and in New Jersey, **facilities have the same problems year-over-year**.
- DOH has independent authority to impose penalties, revoke a license, appoint a receiver or temporary manager or cease new admissions for violations of New Jersey requirements. Historically, **DOH has not exercised this authority**.
- Complaints and other quality data are reported to several different entities, including the LTC Ombudsman, DHS, Medicaid managed care plans and DOH, but **are not aggregated. No one has a full picture of the quality of care or recurring issues**.

Examples From Other States

- **Nebraska** commenced receivership against Skyline, and **Minnesota** has been a receiver and engaged a managing agent for a facility at least three times in the last ten years.
- **Massachusetts** creates and publishes its own performance report for each facility, which includes changes of ownership. It also performs state licensure surveys biannually. Its Center for Health Information and Analysis collects significant data about the quality, affordability, utilization, access, and outcomes of the health care system in the state.



Improve Oversight of and Increase Penalties for Non-Compliant Facilities: Recommendations

Intermediate to Longer-Term Recommendations



- Increase DOH funding and staff so that **surveys can be performed and complaints can be investigated timely**; perform **licensure surveys** of poor performing facilities **at least every two years** that **focus on fewer areas and validate through observation** that the facility actually complies with its policies. Require DOH to perform a survey of infection control and sanitation compliance of each facility every six months.
- **Impose more serious sanctions—using New Jersey’s independent authority as needed—for top priorities.**
 - Impose more **serious sanctions for infection control deficiencies**.
 - Exercise existing authority to **impose more serious sanctions for non-compliance with state licensure requirements**. Penalties should **escalate when the same deficiency is found on a subsequent survey** or during a complaint investigation.
 -  Revise the regulations to **increase the financial penalties for non-compliance**.
 - Terminate, revoke the license of, require temporary management of, or prohibit new admissions to poorly performing facilities (e.g., ones that have repeat serious deficiencies, such as reusing single use equipment with multiple residents, or have a One Star Rating for consecutive years).
 - **Evaluate whether any willing provider requirement should continue – i.e., whether managed care plans should be empowered to end or suspend their contracts with troubled facilities** – and identify any other ways DHS can enhance Medicaid managed care plans’ role in monitoring quality as part of network management and in coordination with DOH’s quality oversight.
 - Leverage data obtained by CMS, DHS, DOH, Medicaid managed care plans, and the LTC Ombudsman to develop **more robust reporting to identify consistently poor performing facilities** and those with a high number of substantiated complaints.
 - Produce a **nursing home report card for each facility** that includes quality, complaint, and other information.



Rationalize and Centralize LTC Data Collection and Processing: Context

Context

- New Jersey's LTC industry, DOH, DHS and DOH's Division of Public Health Infrastructure, Laboratories & Emergency Preparedness are not equipped with the technology, data, or analytic staff to **support ongoing data-driven oversight or to rapidly respond** to public health emergencies:
 - LTC facilities **struggle to understand and submit reliable data** to satisfy a patchwork of ever-changing federal, state and Medicaid managed care plan reporting requirements.
 - State regulators are **challenged to meaningfully collect, curate, analyze and use the limited data** received to support their core regulatory and program oversight functions (e.g., capacity to measure and monitor population health/acuity).
- Industrywide underinvestment in modern technological and analytic infrastructure and reporting has created an **opaque, data-poor regulatory ecosystem that lacks nimbleness** to scale to regulatory need.
- Similar to other states, during the pandemic, New Jersey has **relied on contractors and associations** to scale its information sharing capacity and deploy the most expedient system to stand-up in some ways "makeshift" systems to quickly respond to the crisis, but will need to migrate that data capacity and management in-house or cement a longer-term solution.

Examples From Other States

- [Massachusetts](#) published its first statewide nursing facility industry report in 2019, highlighting occupancy, operating expense, utilization and staffing data, and leveraged this data reporting infrastructure to quickly collect data from nursing homes on their COVID-19 needs.
- [Minnesota](#) publicly provides information on nursing home staffing, rates, and quality.
- [California](#) collects and releases comprehensive LTC facility financial [data](#) and utilization [data](#) in machine-readable and easily-analyzable formats as part of its transparency efforts.



Rationalize and Centralize LTC Data Collection and Processing: Recommendations

Near-Term Recommendations

1. Take actions to improve exchange of and access to critical information:

- **Consolidate state and federal LTC COVID-19 reporting** through the New Jersey Hospital Association (NJHA) PPE, Supply & Capacity portal; assess current LTC facility COVID-19 reporting demands and standardize and consolidate them, where possible.
- **Migrate NJHA portal** onto DOH infrastructure; clearly communicate changes to LTC facilities.
- **Establish centralized state LTC facility communication protocols** to reduce duplicative outreach and increase information sharing; centralize internal COVID-19 and LTC facility data reporting and storage to support cross-governmental information sharing (e.g., DOH, DHS, county OEM, local health departments); establish automatic “alerts” to governmental points-of-contact, generated from LTC facility COVID-19 data submissions that exceed established thresholds.
- Provide smaller LTC facilities with **support** (e.g., financial, staffing, technical assistance) to improve their health information technology (HIT) capabilities, including data reporting.
- **Compile complaints** received across state agencies and review on a regular basis at the central emergency response system.



2. Implement new data reporting requirements:

- Focus should be on increasing market transparency and facilitating ability to enhance regulatory oversight.
- Require LTC facilities to **publicly post (i.e., on websites) policies** otherwise required to be compliant with state law, including outbreak response plans, and have designated staff available to answer questions on policies.



Rationalize and Centralize LTC Data Collection and Processing: Recommendations (*cont.*)

Intermediate to Longer-Term Recommendations

1. Develop centralized, rationalized, and scalable **data and information-sharing infrastructure and protocols.**
 - Identify opportunities to eliminate duplicative reporting and/or standardize reporting requirements.
 - Establish a **centralized, cross-agency workgroup** to monitor LTC-related data reporting.
 - **Assess state HIT needs** to support technology-enabled and data-driven regulatory oversight across departments and prospective uses (e.g., New Jersey Health Information Network, DHS risk adjustment); identify opportunities to **centralize and modernize state health data infrastructure, processes, and analytic capabilities.**
 - **Assess LTC facility HIT needs** to support population health management, interoperability, and modernized reporting requirements.
 - **Identify and apply for federal funding** to support infrastructure development.
-  2. Implement new **data reporting requirements to increase market transparency and enhance regulatory oversight.**
 - Identify new data required from LTC facilities to support **priority, cross-departmental regulatory needs**; solicit nursing home and managed care plan feedback on draft requirements, obtaining input on most efficient method of data collection and specification; evaluate duplication of reporting across federal government, state agencies and managed care plans that might be streamlined or automated; promulgate reporting requirements.
 - **Analyze data for oversight purposes**, and make **results public** when possible.
 - **Produce public, annual report on the performance of New Jersey's LTC system.**



Improve Safety and Quality Infrastructure in Nursing Homes: Context

Context

- Promoting a **safe and effective LTC system is a shared goal**. Nursing homes must be safe, but they also must raise the bar and improve quality.
- **Infection control deficiencies are the most common type of deficiencies** cited for nursing homes; Approximately [one-third](#) of nursing homes surveyed by New Jersey were cited for an infection prevention and control deficiency in 2017. Lessons learned from an infection [outbreak](#) in a New Jersey facility in 2018 that resulted in the mortality of 11 children could have been more widely implemented and leveraged as a catalyst for cultural change for other facilities and the state.
- **Quality improvement has multiple dimensions** including structural (i.e., appropriate staffing, infection control expertise, access to clinical consults as needed); process (i.e., protocols for infection control, training on use of PPE, etc.) and outcomes (i.e. reduction in adverse events like falls with injury, bed sores, onset of pneumonia, increase in social connectedness, functioning level, satisfaction with service and support by residents and families, among others).
- Level of **clinical engagement and oversight** (including role of the medical director), ensuring **continuity of care** during an emergency (including review of care plans, advance directives, palliative care, coordination of medical care, and transitions across care settings), and **competency-based staffing and training** are also important factors in building a **culture of quality**.*
- Federal and state LTC oversight processes **focus almost exclusively on citing and penalizing facilities**. These are critical functions but there are **few opportunities for facilities to receive support and technical assistance** to improve their quality. Those that need help may be hesitant to disclose challenges for fear of penalties.
 - New Jersey's Infection Control Assessment & Response (ICAR) program provides consultations to facilities to strengthen infection prevention, but funding for ICAR is dwindling, its capacity is limited, and its services do not extend to broader quality improvement.

Examples from CMS and Other States

- **CMS** has a targeted Probe and Educate program that helps providers reduce claims denials and appeals through one-on-one help.
- **Florida** deploys Rapid Emergency Support Teams to 200+ LTC facilities to train staff on infection controls and augment clinical patient care.
- **Missouri** has a Quality Improvement Program that offers individual nurse consultation and technical assistance for the completion of certain assessments, quality improvement, as well as support groups and workshops.



Improve Safety and Quality Infrastructure in Nursing Homes: Recommendations

Near-Term Recommendations



Infection Control

- Mandate that **every facility have a senior-level Infection Control Preventionist (ICP)*** who reports to the CEO and the Board of Directors. For facilities with over 100 beds, this position should be full-time and the person should not have any other responsibilities.
- **Request additional funding for the ICAR program** (e.g., via civil monetary penalty funding pools).
- In addition, **contract with a vendor or other entity able to rapidly assist in training and technical assistance** on infection control. For example, Rutgers University and NJHA have relevant experience to rely on.

• Broader Quality Improvement

- **Provide resources** (e.g., civil monetary penalty funding pools) for a program either within DOH (but outside of the enforcement arm) *or* a vendor to provide **technical assistance to facilities on quality improvement, best practices, or compliance** with specific requirements, and that periodically reviews whether the technical assistance is indeed improving quality of the nursing homes it supports.
- Consider a pilot program whereby a **reviewer follows a cohort of residents for a period of time to see how the facility's quality of care is improving** (as the survey focus is oriented to review at a given point in time).

Proposed Responsibilities of ICP

- Developing **robust policies and procedures and a training curriculum** for the nursing home, which should be informed by best practices and clinical expertise, and includes training on use of PPE.
- Evaluating whether the CNA training curriculum provides **sufficient hands-on training** in infection control and prevention.
- Implementing **routine monitoring of infection prevention activities** and **initiate discipline for those who routinely violate prevention policies**.
- Reporting to the CEO and Board of Directors, at least quarterly, on the effectiveness of such activities and number of infections/quarter.
- Requiring nursing homes to perform **quarterly emergency and infection control drills, i.e. activating their plans to ensure they are actionable and effective**.

* Despite federal and state mandates for an infection prevention and control program, many facilities **lack a culture of infection prevention**: staff receives minimal infection control training, and much of it is ineffective because it is part of long, slide-based training or is simply a handout. There is a federal requirement that each nursing facility have a part-time infection preventionist (IP) at least part-time. 42 CFR § 483.80 (b)). CMS has proposed to revise this requirement so that a facility only has to ensure that the IP has sufficient time at the facility to meet the objectives of its infection prevention and control program. New Jersey mandates each facility have an employee who is designated as an infection control coordinator. N.J.A.C. 8:39-19.1



Improve Safety and Quality in Infrastructure Nursing Homes: Recommendations

Intermediate to Longer-Term Recommendations



Infection Control

- Perform targeted surveys every six months to assess whether the facility implemented effective infection control and prevention measures.

• Quality Improvement

- Require targeted surveys if policies and protocols appear ineffective as evidenced by concerning metrics that do not decrease over time, such as number of falls, onset of pneumonia, increase in social connectedness, functioning level, satisfaction with service and support by residents and families.
- Institute a “**probe and educate model**” to help identify quality of care risks and deficiencies and provide the tools for education and **improvement**. This would include a non-punitive review of the facility focusing on viewing policies and procedures in action and access and use of clinical consults. Resident outcomes information would not be shared with the surveyors. The probe and educate model would perform a baseline review, then return to the facility to assess improvement following education, and continue the loop until improvement is made or other action needs to be taken.
- In concert with recommendations from the proposed Governor’s Task Force, **evaluate staffing levels and competency by resident acuity and complexity** and impose **greater responsibility and accountability on the medical director** for quality outcomes.
- Continue to expand DHS’s **Quality Incentive Payment Program** for nursing homes.



Strengthen State Agency Organization and Alignment Around LTC: Context

Context

- Today, **oversight of the LTC system is spread across DOH and various divisions within DHS**. No single department or division is responsible and accountable for overseeing the LTC system as a whole.
- The pandemic has shed light on the need for **strong cross-agency alignment and communication** to ensure that the state has a **cohesive LTC policy, financing, licensing, oversight and regulatory strategy** and that LTC activities are **aligned and coordinated** across the departments.
- From 2008 to 2019, combined staffing at DOH and DHS [decreased](#) by approximately 30% and key DOH positions remain open. To help the state be more responsive to the LTC system during regular operations and emergencies, DOH should focus on expanding its leadership team to bring in additional LTC expertise.
- Similarly, DHS through the Medicaid program has primary responsibility for care delivery and financing but **lacks the resources to develop essential data analytic capacity and other expertise** needed to move delivery and payment reforms forward.

Examples From Other States

- **Massachusetts'** LTC licensing, survey, regulatory, policy and rate-setting agencies are all housed under the Executive Office of Health and Human Services (EOHHS). While multiple agencies, such as MassHealth (Medicaid), the Department of Public Health, Elder Affairs and several disability and community services agencies, regularly collaborate on LTC strategies and activities, ultimate decision-making and accountability for LTC leadership and strategy lies with the Secretary of EOHHS.



Strengthen State Agency Organization and Alignment Around LTC: Recommendations

Near-Term Recommendations

- Consider designating one of the existing Deputy Commissioners or establish a new Deputy Commissioner-level position at DOH to be responsible for overseeing and coordinating all activity across the LTC system.
- Develop a formal workplan for DOH and DHS to align and troubleshoot on LTC issues and coordinate on key ongoing priorities impacting both departments, such as data-driven monitoring, quality, and payment methodology.
- Continue effort to fill vacant position for DOH Deputy Commissioner of Public Health Services as soon as possible.

Intermediate to Longer-Term Recommendations

- Review current DOH and DHS staffing structures to identify additional positions and LTC expertise that may be needed, including:
 - Ongoing regulatory and licensing oversight at DOH.
 - Data analytics at DHS.



Create Governor's Task Force on Transforming New Jersey's LTC Delivery System: Context

Context

- COVID-19 has exposed long-standing nursing home **staffing and workforce challenges, outdated care models that do not reflect the diverse needs of residents, outdated physical plants of facilities, and other structural deficiencies** in New Jersey's LTC system. At the same time, the provider landscape has changed significantly in recent years.
- Most people prefer to remain in their homes as long as possible, supported by HCBS instead of institutional settings. While New Jersey lagged far behind with respect to the proportion of LTC provided in the home, **it has greatly increased its provision of HCBS in recent years and is seeking to further augment its efforts to allow people needing long-term services and supports (LTSS) to remain in the community.**
- New Jersey has an opportunity to be a leader in developing a **forward-looking vision and approach to redesigning institutional and community-based care models, services, payment, staffing, and best practices for modernizing facilities** to not only better guard against potential future infections but to transform care for the high-risk individuals who use LTC.

Examples From Other States

- **Massachusetts** created the Nursing Facility Task Force in 2019 via legislation, charged with evaluating ways to ensure the financial stability of SNFs; considering the role of SNFs within the continuum of elder care services; and addressing current workforce challenges.
- **California**. Governor Newsom issued an executive order directing the Secretary of Health and Human Services to convene a cabinet-level workgroup to develop a "Master Plan for Aging." The Master Plan will be a blueprint for state and local government and the private and philanthropy sectors to "promote healthy aging" in light of an aging and diversifying state population. Priorities for the Master Plan include independence and choice for seniors and will include recommendations for coordinating federal, state, and local government programs and services, and 10-year targets for implementing recommendations.



Create Governor's Task Force on Transforming New Jersey's LTC Delivery System: Recommendations

Intermediate to Longer-Term Recommendations

- Establish a Governor's Task Force charged with **developing actionable recommendations** to reform the LTC system centered around person-centered care, safety, quality improvement, workforce engagement and sustainability.
- The Task Force could be comprised of a **diverse panel** of policymakers, nursing and medical professionals, labor representatives, experts on LTC and aging and disability policy, consumer/resident representatives, and representatives from nursing homes (among potentially other providers) appointed by the Governor.
- The Task Force would consider factors related specifically to create the **optimal balance of services and supports, including continued expansion of HCBS, nursing home reforms and broader system reforms.**
 - Nursing home reforms could consider new **care models** for nursing homes, optimal nursing **home size** and **configuration** for both resident wellness (e.g., create smaller internal communities that foster on-going relationships with staff) and infection control, policies for **increasing clinical presence** in nursing homes, and nursing home **staffing levels** and **ratios** based on acuity or special population needs.
 - Broader system reforms could consider technology requirements for all LTC providers to more easily enable **telehealth**, **career laddering** or other models for LTC **workforce engagement and advancement**, the role of **Medicaid managed care in quality improvement and oversight** of nursing homes, and **acuity adjustments** for Medicaid managed care payments to nursing homes.

- **Appendix A.** Additional Considerations: Federal Collaboration
- **Appendix B.** Timeline of Key State Actions Addressing COVID-19 At LTC Facilities
- **Appendix C.** Summary of Federal Actions Addressing COVID-19 At LTC Facilities
- **Appendix D.** Overview of Selected Federal Funding
- **Appendix E.** New Jersey Nursing Home Profile
- **Appendix F.** Analyses of COVID-19 by Region, Quality Ratings, Staffing and Ownership Type
- **Appendix G.** Other State and Local Responses
- **Appendix H.** References

APPENDIX A. ADDITIONAL CONSIDERATIONS: FEDERAL COLLABORATION

Additional Considerations – States Need a Federal Partnership

Nursing home residents are among the most susceptible to severe illness and adverse outcomes from COVID-19. The national experience and emerging data (not only New Jersey's) indicate that the nursing home environment is conducive to the rapid spread of the virus, almost certainly from many of the same underlying systemic issues discussed in this report.

Responsibility for regulations, oversight, and funding of nursing homes is shared between states and the federal government. While the scope of recommendations in this report are limited to action by the State of New Jersey and/or the nursing homes under its jurisdiction, several opportunities for federal support of the state's efforts and/or closer federal-state partnership around industry transformation are evident. Select examples (by no means comprehensive) include:

- **Prioritization of COVID-19 Testing for Nursing Home Residents and Staff.** Nursing home residents and staff should be prioritized for testing kits and supplies, with clear direction related to payment responsibility, at *both* the federal and state level - particularly in the near-to-mid term as our collective understanding of prevention and treatment options evolves. One option could be for Medicare Part A to cover recommended testing for nursing home residents. Given the acute need for ongoing testing and monitoring, a national plan for nasal as well as alternate collection and serological testing for nursing homes should be developed as/if those testing approaches become more reliable.
- **Stronger Role of Infection Preventionist.** Prior to the pandemic, CMS proposed to [lessen requirements](#) for the infection preventionist. Learnings from the pandemic demonstrate a need for continuous vigilance, and there may be an opportunity to elevate and strengthen that role, as part of a broader effort to further foster a culture of safety and continuous quality improvement in our nation's nursing homes.
- **More Flexible, Targeted Oversight.** Effective, targeted state oversight and appropriate intervention for struggling nursing homes is critical – and all the more tenuous as states face challenging finances and [budget cuts](#) in the wake of sharp economic declines. CMS's current nursing home survey requirements (temporary flexibilities for the pandemic notwithstanding) are highly prescribed and standardized. Flexibilities around frequency are needed, including consideration of a model whereby struggling facilities receive more comprehensive surveys more frequently and stronger performers alternate between full and limited surveys. This could free up resources for the state to focus on and provide interventions and support for areas that are low performing across all nursing homes nationally, such as infection control.
- **Increased Funding for Oversight and Technical Assistance.** In concert, increased funding for survey and oversight as well as technical assistance for safety and quality improvement furnished at the federal and state level is likely warranted.

Additional Considerations – States Need a Federal Partnership (*cont.*)

Availability of HIT Funding. Nursing homes, along with other post-acute and LTC providers, largely have been excluded from federal efforts to expand the use of electronic health records and health information exchange (HIE). Evaluation of opportunities to enhance health IT and HIE funding for nursing homes to enable better data analytics, sharing and reporting and to allow nursing homes to take advantage of the implementation of new Fast Healthcare Interoperability Resource (FHIR)-based application programming interface (APIs) and expanded trusted information exchange frameworks should be prioritized in the wake of the pandemic.

Better Targeting of PPE. Given the ongoing national shortages of PPE, in its planning for potential future waves or case surges, the federal government should use [FEMA](#) and other resources to both direct most acutely needed PPE for nursing homes and give more specific guidance on specific types and uses of PPE for nursing home staff and visitors.

Reforms to Nursing Home Staffing and Care Model. A national conversation is needed on staffing ratios, clinical acuity-based staffing and competencies, and high quality services for distinct sub-patient populations, among other important issues. CMS has [announced](#) the formation of an independent commission to address safety and quality in nursing homes. Further opportunity exists to reconsider the nursing home model and develop recommendations for forward-looking care transformation.

Increased Flexibility in Care Delivery. The federal government has granted many flexibilities under the public health emergency period, including expanded use of telemedicine and flexibilities related to staffing. Consideration should be given as to the flexibilities that should be retained in whole or in part after the pandemic ends.

APPENDIX B. TIMELINE OF KEY STATE ACTIONS ADDRESSING COVID-19 AT LTC FACILITIES

Key State Actions Addressing COVID-19 at LTC Facilities

February and March Activity

Week of February 3

- Facilitated a discussion at the New Jersey Hospital Association on preparing for a novel coronavirus.

Week of March 2

- [Guidance](#) issued to LTC facilities on preparing for COVID-19, based on available CDC guidance.
- Memo issued to LTC facilities reminding them of their statutory responsibility to have a disaster response plan.

Week of March 9

- DOH held Coronavirus Preparedness Briefing call with LTC facilities.

Week of March 16*

- Visitors [restricted](#) from nursing homes except for end-of-life visits, with screening and protection requirements. Staff monitoring and screening requirements put in place.
- Additional and updated [recommendations](#) provided to all LTC facilities, including information on resource planning, resident and staff education, screening protocols, developing an infection control plan, and surveillance and tracking.
- DOH and DHS submitted to CMS two [1135 waiver](#) requests.

Week of March 23**

- Series of action taken to support and supplement LTC workforce, including extending recertification deadlines, allowing facilities to use certified nurse assistants (CNAs) certified in another state, and allowing registered medical technicians and certified home health aides to function as CNAs in LTC facilities.
- [Executive Order](#) requires all health care facilities, including LTC facilities, to report daily data on their capacity and supplies of PPE to the New Jersey Office of Emergency Management. Reporting is done through a portal currently hosted by the New Jersey Hospital Association.

Week of March 30

- [Guidance](#) issued on statutorily mandated notification of residents, families, visitors and staff in the event of contagious disease outbreak in a facility.
- Infection prevention and mitigation [guidance](#) issued on restricting visitors, active screening, cohorting within a facility, ending communal dining, universal masking, “optimizing” PPE, and reviewing staff contingency plans.
- [Guidance](#) issued on hospital discharges and admissions to post-acute settings.

*Beginning March 19, the New Jersey Hospital Association began hosting weekly infection control conference calls, with DOH participation. These calls continue to date.

**During the week of March 23, DOH also [assisted](#) St. Joseph’s in Woodbridge in relocating all of its residents to a different nursing home that became a COVID-only facility.

Key State Actions Addressing COVID-19 at LTC Facilities *cont.*

April Activity

Week of April 6

- Outbreak management [checklist](#) distributed to nursing homes.

Week of April 13

- State Attorney General [announces](#) investigation into nursing home deaths.
- Guidance [issued](#) curtailing admissions order.
- Expanded pool of CNAs by allowing personal care assistants and certified medical assistants to function as CNAs, and allowing nursing homes to hire temporary nurse aides who complete a state-approved online course offered by the American Health Care Association.

Week of April 20

- Statewide list of cases in nursing homes released to the public.
- Following PPE has been distributed to facilities based on self-reported need: 458,000 N95 masks, 2.1 million surgical masks, 58,000 face shields, 27,000 surgical gowns, 1.7 million gloves.
- “Volunteer” portal launched for health care professionals. At least 25 nurses registered through the portal are sent to work in veterans homes.
- Outbreak reporting and response [guidelines](#) for LTC facilities issued to local health departments.
- With Rutgers Medical School, hosted a Project ECHO [teleconference](#) for LTC providers about infection prevention and control in LTC settings.

Week of April 27

- National Guard medics deployed to two state veterans homes to supplement facility staff.
- With Rutgers Medical School, hosted a Project ECHO [teleconference](#) for LTC providers about end-of-life planning in LTC settings.

Key State Actions Addressing COVID-19 at LTC Facilities *cont.*

May Activity

Week of May 4

- Online [portal](#) established for the public to anonymously report misconduct in LTC.
- Announcement made that the state's three veterans homes are offering universal testing. Private consortium of nursing homes and hospitals announce it will test 10,000 residents and 20,000 staffers at 74 facilities in the state over the course of two weeks.
- State [allows](#) temporary emergency licenses to be granted to recent graduates of nursing, physician assistant, pharmacy and respiratory care therapy programs.
- At least 300 National Guards are deployed to nursing homes across the state.

Week of May 11

- All LTC facilities are [required](#) to add a COVID-19 testing plan to their current disease outbreak plan. The testing plan must include:
 - Baseline molecular testing of all staff and residents by May 26 (deadline was later extended to May 30).
 - Retesting all negative staff and residents within 3-7 days of baseline testing.
 - Further retesting in accordance with CDC guidance.
- CMS approved New Jersey's Medicaid Appendix K: Emergency Preparedness and Response submission.

Week of May 18

- As testing continues, state announces 650 residents at the three veterans homes have been tested (more than half found positive), and 14,000 residents and 42,000 staff at 100 privately run LTC facilities have been tested.
- Issued FAQ on testing plan Executive Directive (see above).

Week of May 25

- Expanded testing plan [FAQs](#) issued.

APPENDIX C. SUMMARY OF KEY FEDERAL ACTIONS ADDRESSING COVID-19 AT LTC FACILITIES

Summary of Federal Policy Guidance and Select Additional Actions in Response to COVID-19 in Nursing Homes

Policy & Memos to States and Regions

CMS Quality Safety & Oversight memoranda, guidance, clarifications and instructions to State Survey Agencies and CMS Regional Offices for Nursing Homes (all policy memos can be accessed [here](#)):

- COVID-19 Survey Activities, CARES Act Funding, Enhanced Enforcement for Infection Control deficiencies, and Quality Improvement Activities in Nursing Homes (June 1)
- Nursing Home Reopening Recommendations for State and Local Officials (May 18)
- Interim Final Rule Updating Requirements for Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff in Nursing Homes (May 6)
- Nursing Home Five Star Quality Ratings System update; Nursing Home Staff Counts; and Frequently Asked Questions (April 24)
- Upcoming Requirements for Notification of Confirmed COVID-19 (or COVID-19 Persons under Investigation) Among Residents and Staff in Nursing Homes (April 19)
- 2019 Novel Coronavirus Long-Term Care Facility Transfer Scenarios (April 13)
- Prioritization of Survey Activities (March 23)
- Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes (REVISED) (March 13)
- Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes (March 4)
- Suspension of Survey Activities (March 4)
- Release of Additional Toolkits to Ensure Safety and Quality in Nursing Homes (Feb. 14)
- Information for Healthcare Facilities Concerning 2019 Novel Coronavirus Illness (Feb. 6)

Recent Additional Agency Actions:

- HHS sent additional provider relief payments directly to nursing homes ([May 22](#))
- CDC released updated resources and tools for nursing homes ([May 19](#))
- CDC updated Interim Testing Guidance in Response to Suspected or Confirmed COVID-19 in Nursing Home Residents and Healthcare Personnel ([May 19](#))
- CMS issued phase reopening guidance FAQs ([May 18](#))
- CMS published informational tool kit to reduce prevalence of COVID-19 in nursing homes, cataloguing state practices and state directives ([May 13](#))
- FEMA coordinated two shipments totaling a 14-day supply of PPE directly to approx. 15,000 nursing homes nationwide ([May 4](#))
- CMS announced it will form an independent commission to address safety and quality in nursing homes ([April 30](#))
- CMS published COVID-19 Long Term Care Facility Guidance Sheet ([April 2](#))
- In addition, on a rolling basis, CMS has provided several [waiver flexibilities](#) in effect during the public health emergency period related to workforce capacity, telehealth expansion, surge capacity planning, and other, with some broadly applicable to providers and some specific to [LTC facilities](#)

Additional Considerations – Nursing Home “Reopening”

There is no one-size-fits-all formula for all nursing home reopening. There are clear foundational elements: strong bidirectional communications mechanisms, an effective infection control plan (with enough and the right kind of PPE, sufficient disinfectant supplies, a consistent handwashing protocol, and the ability to cohort residents and staff, among other elements) and a rational, regular testing plan for residents and staff.

In addition, clinical input, the acuity of residents’ health status (including underlying chronic conditions and mental status), local/regional community outbreak trends, capacity for local/regional contract tracing, level of training on infection control protocols, familiarity of staff with protocols and individual residents (especially in times of temporary staffing), potential adjustments to symptom and vitals checks (such as frequency, addition of pulse-oximetry, for example) and the specifics of an individual facility’s design, layout, room configuration and age are also factors that have to be taken into account.

In concert with “reopening” plans must be contingency plans to quickly restrict access and/or impose greater infection control measures and to ensure robust ongoing monitoring and communications. CMS and CDC have recently issued new guidance, which they continue to update:

Reopening to Visitors

In its [May 18 guidance](#), CMS recommends nursing homes follow a staged or phased reopening process. CMS does not recommend opening facilities to visitors (**except for compassionate care situations**) until phase three when:

- At least 28 days without a new COVID-19 case originating on-site (as opposed to accepting a patient with COVID-19 transferred from a hospital, for example)
- The nursing home is not experiencing staff shortages
- The nursing home has adequate supplies of PPE and essential cleaning and disinfection supplies
- The nursing home has adequate access to testing for COVID-19 (which also requires an arrangement with laboratories to process tests)
- Local hospital(s) have capacity

Additional related considerations: community case status, ability for universal source control (e.g., residents, staff and visitors wearing masks or face coverings), ability to ensure social distancing and other measures for visitors, an ability to monitor changes in testing results against a baseline; a policy or procedure for residents and staff who decline tests or cannot be tested.

Infection Control

The CDC continues to update its guidance and resources for nursing homes and long-term care: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>

- CDC suggests that *critical* PPE shortages at the facility level are less than one week supply remaining, despite use of PPE conservation strategies, of: N95 masks • Surgical masks • Eye protection, including face shields or goggles • Gowns • Gloves • Alcohol-based hand sanitizer. (CDC also offers a free PPE burn rate calculator for nursing homes). *An acceptable minimum coupled with reliable supplies must be defined by facility.*

CDC details extensive “Core Practices,” which should remain in place even as nursing homes resume normal activities, related to a wide-ranging set of issues (including cohorting, testing, PPE protocols, training, among others) for infection control during the COVID-19 emergency

Compilation of CMS guidance related to COVID-19: <https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page>

APPENDIX D. OVERVIEW OF SELECTED FEDERAL FUNDING

Federal COVID-19 Funding Sources – Provider Relief Fund

Funding	Background	Funding Description and Relevance to Nursing Homes	Links
Public Health and Social Services Emergency Fund (PHSSEF) Administered by HHS	Congress has appropriated \$175 billion for health care providers to prevent, prepare for, and respond to COVID-19 to be distributed through grants and other payment mechanisms. Eligible expenses include lost revenues, building new structures or retrofitting existing buildings, purchasing supplies, training staff, and other COVID-19-related costs. The CARES Act provided an initial \$100 billion for this fund. Under the “CARES 3.5” Act - the Paycheck Protection Program Increase Act of 2020 – Congress appropriated an additional \$75 billion to the fund.	April 2020: HHS allocated \$50 billion to providers via a “General Distribution Fund” based on 2018 net patient revenue. Only providers who billed Medicare fee-for-service in 2019 are eligible for this funding. This funding was directly distributed based on the assumption of COVID-related costs or lost revenues. - HHS initially released \$30 billion based on a provider’s proportionate share of 2019 Medicare fee-for-service total payments. - HHS has distributed an additional \$20 billion to providers allocated such that, when added to the initial distribution, it will equal a provider’s proportionate share of 2018 net patient revenues. - Providers must sign an attestation and agree to a specific set of Terms & Conditions (T&Cs) within 90 days of receiving payment. - Nursing homes in New Jersey that billed Medicare FFS in 2019 would be eligible for funds from this pool; the amount will vary by facility and all total allocations have not been disclosed yet. On May 22, 2020: HHS announced it will make additional relief fund distributions to SNFs based on both a fixed basis and variable basis. Each SNF will receive a fixed distribution of \$50,000, plus a distribution of \$2,500 per bed. All certified SNFs with six or more certified beds are eligible for this targeted distribution. NJ SNFs will receive \$170,215,000. SNFs must comply with a set of T&Cs related to this funding. Funding can be used to offset lost revenues and/or COVID-related expenses after January 31, 2020.	Provider Fund overview: https://www.hhs.gov/coronavirus/care-act-provider-relief-fund/index.html Database of providers that have attested to receiving Provider Relief Fund monies (from \$50 Billion General Distribution Fund) updated weekly, based on provider attestations: https://data.cdc.gov/Administrative/HHS-Provider-Relief-Fund/kh8y-3es6 New SNF distribution: https://www.hhs.gov/about/news/2020/05/22/hhs-announces-nearly-4.9-billion-distribution-to-nursing-facilities-impacted-by-covid19.html State by state breakdown of SNF distribution: https://www.hhs.gov/sites/default/files/skilled-nursing-facility-provider-relief-payment-state-breakdown.pdf May 22 SNF-specific funding T&Cs: https://www.hhs.gov/sites/default/files/terms-and-conditions-skilled-nursing-facility-relief-fund.pdf

Federal COVID-19 Funding Sources – Loans

Funding	Background	Funding Description and Relevance to Nursing Homes	Links
Medicare Accelerated and Advanced Payment Program Administered by CMS	(CARES Act) The CMS Accelerated and Advance Payment (AAP) Program is designed to increase cash flow to Medicare providers and suppliers impacted by the pandemic.	Note: On April 26, CMS announced that, <u>effective immediately</u>, it is no longer accepting new applications for the Advance Payment Program (which applies to Part B suppliers) and that it is “reevaluating” the amounts that will be paid via the Accelerated Payment Program (which applies to Part A providers). Eligible facilities were able to request loans in the form of advance payments, funded from the Medicare Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B). While there is a deferred repayment period, the loans must be repaid.	https://www.cms.gov/newsroom/press-releases/trump-administration-provides-financial-relief-medicare-providers https://www.cms.gov/newsroom/press-releases/cms-reevaluates-accelerated-payment-program-and-suspends-advance-payment-program
Small Business Administration’s (SBA) Paycheck Protection Program Administered by the Department of Treasury	(CARES Act and the Paycheck Protection Program Increase Act of 2020) Expands the SBA’s current loan program and eligibility requirements in order for businesses to pay employees and keep them on payroll during the current COVID-19 crisis and provides for loan forgiveness, with certain limits.	Some small nursing homes may be eligible. Businesses must have no more than 500 employees to be eligible. In determining whether a business has less than 500 employees, affiliates must be aggregated. The maximum amount any eligible business may borrow is the lesser of (i) the business’s average total monthly payroll costs during the one-year period prior to the loan being made multiplied by 2.5, plus the outstanding amount of an SBA disaster loan that was made between January 31, 2020, and the date that such loan is financed with a loan under the Act; or (ii) \$10 million.	https://www.sba.gov/funding-programs/loans/coronavirus-relief-options
Main Street Lending Program Administered by the Department of Treasury	(CARES Act) \$75 billion program Lending program to enhance support for small and mid-sized businesses that were in good financial standing before the crisis by offering 4-year loans to U.S. companies.	Not in effect yet. Program launching early June. Eligible business with less than 15,000 employees or \$5 billion in annual revenue are eligible for loans of as much as \$500,000. Main Street loans are full-recourse loans and are not forgivable.	https://www.federalreserve.gov/monetarypolicy/mainstreetlending.htm

Federal COVID-19 Funding Sources – State Funds

Funding	Background	Funding Description and Relevance to Nursing Homes	Links
Testing Funding – PHSSEF Administered by HHS	(Paycheck Protection Program Increase Act of 2020) The Act appropriates \$25 billion to the PHSSEF to address expenses related to expanded COVID-19 testing. The fund is intended to “prevent, prepare for, and respond to coronavirus, domestically or internationally, for necessary expenses to research, develop, validate, manufacture, purchase, administer, and expand capacity for COVID-19 tests to effectively monitor and suppress COVID-19.”	\$10.25 billion for states, localities, territories sent within 30 days of enactment for “necessary expenses to develop, purchase, administer, process, and analyze COVID-19 tests,” including: • Support for workforce; • Epidemiology; • Use by employers or in other settings; • Scaling up of testing by public health, academic, commercial, and hospital laboratories, and community-based testing sites, health care facilities, and other entities engaged in COVID-19 testing; • Conducting surveillance and contact tracing; and • Other related activities related to COVID-19 testing. The governor or designee of each state must submit to the Secretary a plan for COVID-19 testing within 30 days of the enactment of the Act. The plan must incorporate goals for the remainder of calendar year 2020, including (i) the number of tests needed, month-by-month; (ii) month-by-month estimates of laboratory and testing capacity; and (iii) a description of how the state will use its resources for testing. While some of the balance of the fund is allocated to specific agencies, health clinics and the uninsured, HHS has discretion over a portion of remaining funding.	https://www.congress.gov/116/bills/hr266/BILLS-116hr266eas.pdf
Coronavirus Relief Fund Administered by the Department of Treasury	(CARES Act) \$150 billion to states and local governments, distributed largely in proportion to state population	The CARES Act included broad guidelines for the Fund, which provide that this funding may only be used to cover costs that: • Are necessary expenditures incurred due to the public health emergency with respect to COVID-19; • Were not accounted for in the budget most recently approved as of March 27 (the date of enactment of the CARES Act) for the state or government; and • Were incurred between March 1 and December 30. Additional guidance on use has been published through a series of FAQs.	https://home.treasury.gov/system/files/136/Payments-to-States-and-Units-of-Local-Government.pdf https://home.treasury.gov/system/files/136/Coronavirus-Relief-Fund-Frequently-Asked-Questions.pdf

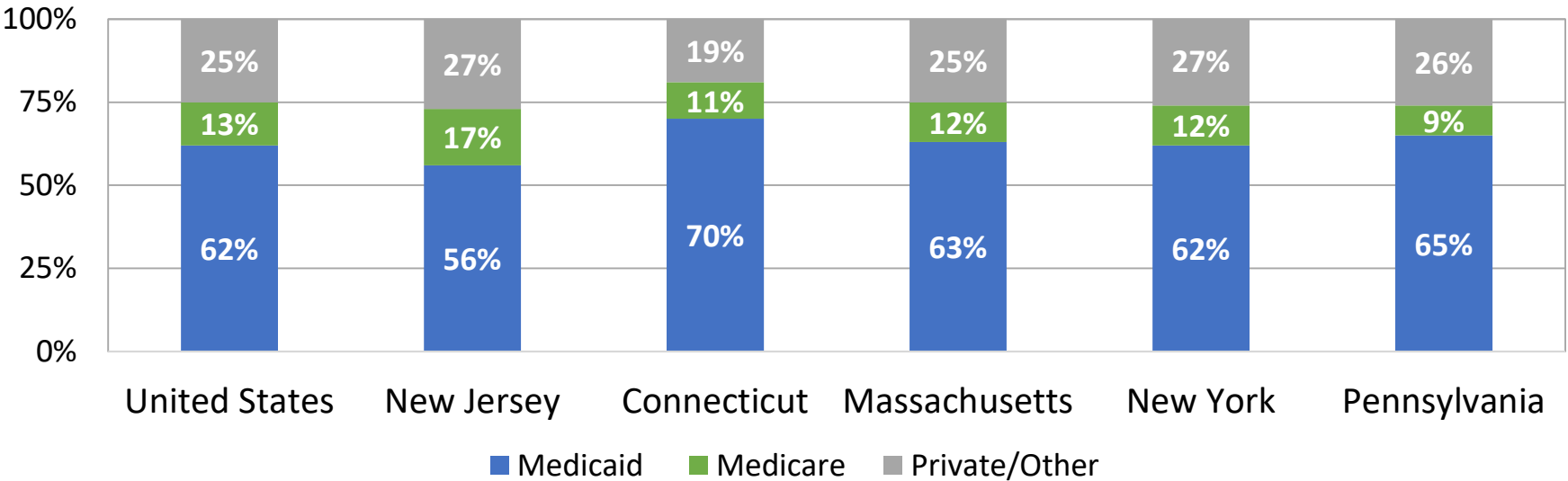
Federal COVID-19 Funding Sources – State Funds

Funding	Background	Funding Description and Relevance to Nursing Homes	Links
Enhanced Federal Medical Assistance Percentage (FMAP)	Families First Coronavirus Relief Act (FFCRA) 6.2 percentage point in FMAP, the federal Medicaid matching rate for each state	The Medicaid program is jointly funded by the federal government and states. The federal government pays states for a specified percentage of program expenditures, called the FMAP. FFCRA applies a 6.2 percentage point increase in federal Medicaid matching rate for every state, retroactive to January 1, 2020, through the last day of the calendar quarter in which the emergency ends. The increased matching rate applies only to expenditures typically matched at the state's regular Medicaid matching rate and not to the enhanced matching rate for the expansion population under the Affordable Care Act. While the federal portion of Medicaid expenditures will increase with the increase in the federal Medicaid matching rate, allowing states to use the portion of the money they would have spent on Medicaid for other uses, Medicaid enrollment is expected to increase as unemployment increases, meaning that overall Medicaid costs are expected to increase. In addition, as a condition of receiving the 6.2 percentage point increase, states must maintain most current beneficiaries in their programs.	https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-faqs.pdf

APPENDIX E. NEW JERSEY NURSING HOME PROFILE

A smaller proportion of New Jersey nursing home residents have Medicaid as their primary payer compared to other states in the region and the nation.

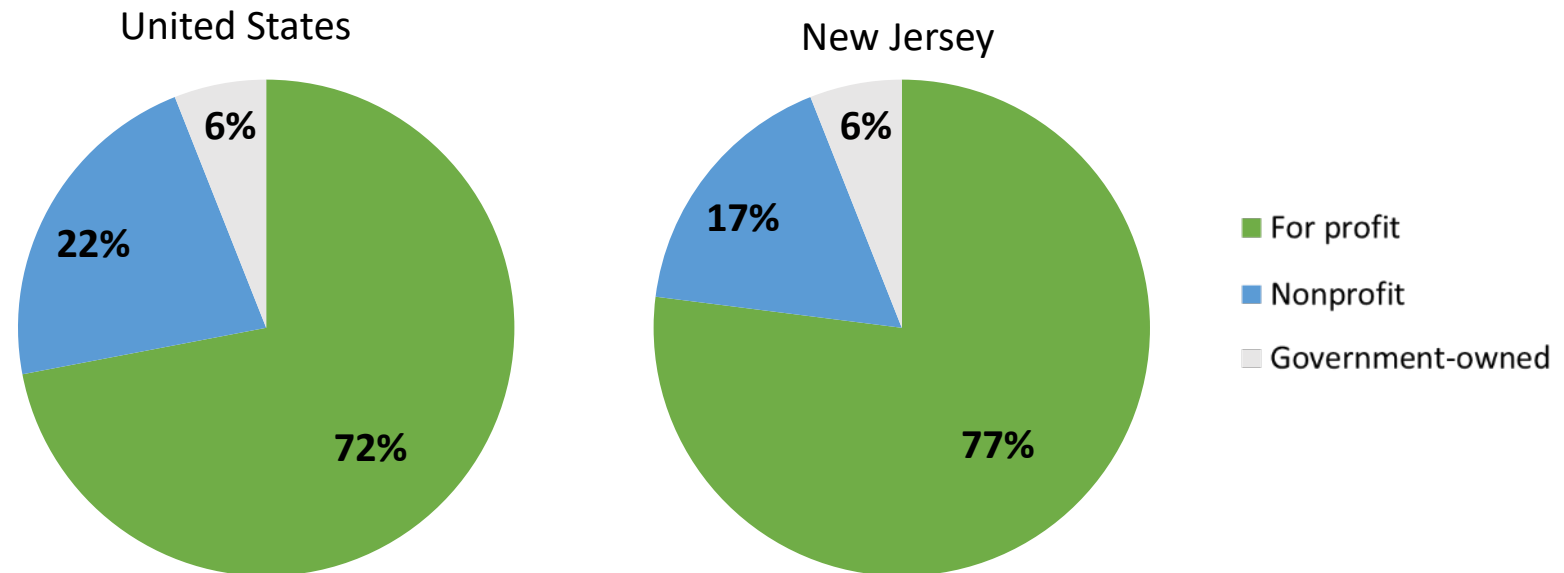
Distribution of Certified Nursing Facility Residents by Primary Payer Source (2017)



Source: Distribution of Certified Nursing Facility Residents by Primary Payer Source, 2017, [kff.org](https://www.kff.org/other/state-indicator/distribution-of-certified-nursing-facilities-by-primary-payer-source/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D), <https://www.kff.org/other/state-indicator/distribution-of-certified-nursing-facilities-by-primary-payer-source/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

A greater proportion of New Jersey nursing home residents reside in for profit nursing homes than in the nation as a whole.

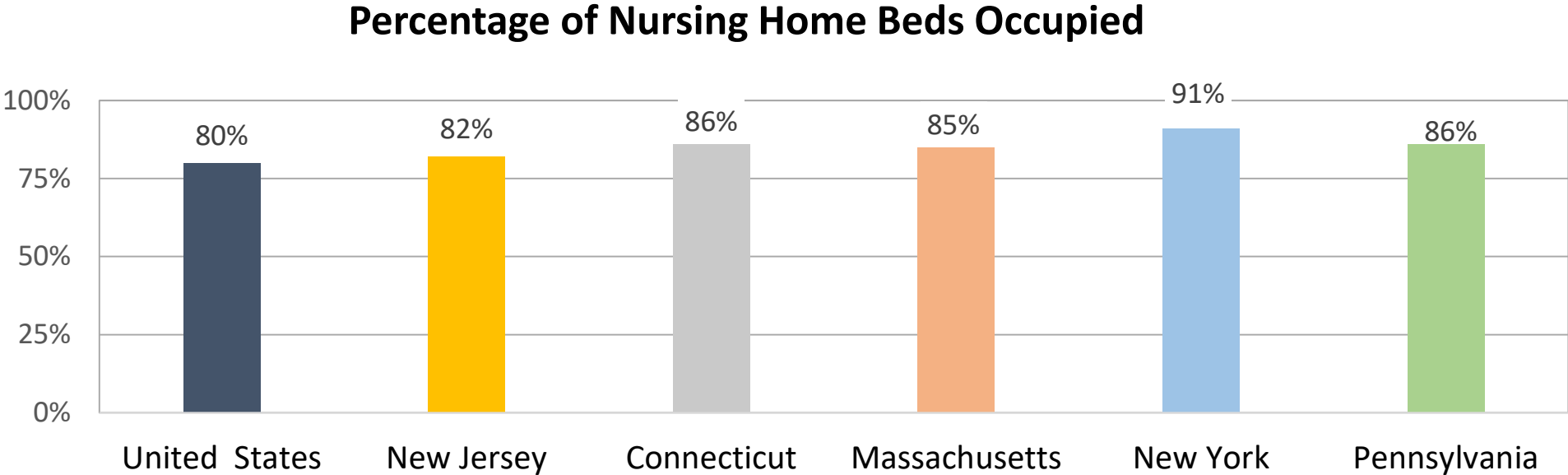
Percentage of Nursing Home Residents Per Day by Ownership Status



Note: In New Jersey, 74% of nursing homes are for profit, 23% are non-profit and 3% are government-owned. Nationally, 70% of nursing homes are for profit, 23% are non-profit and 6% are government-owned.

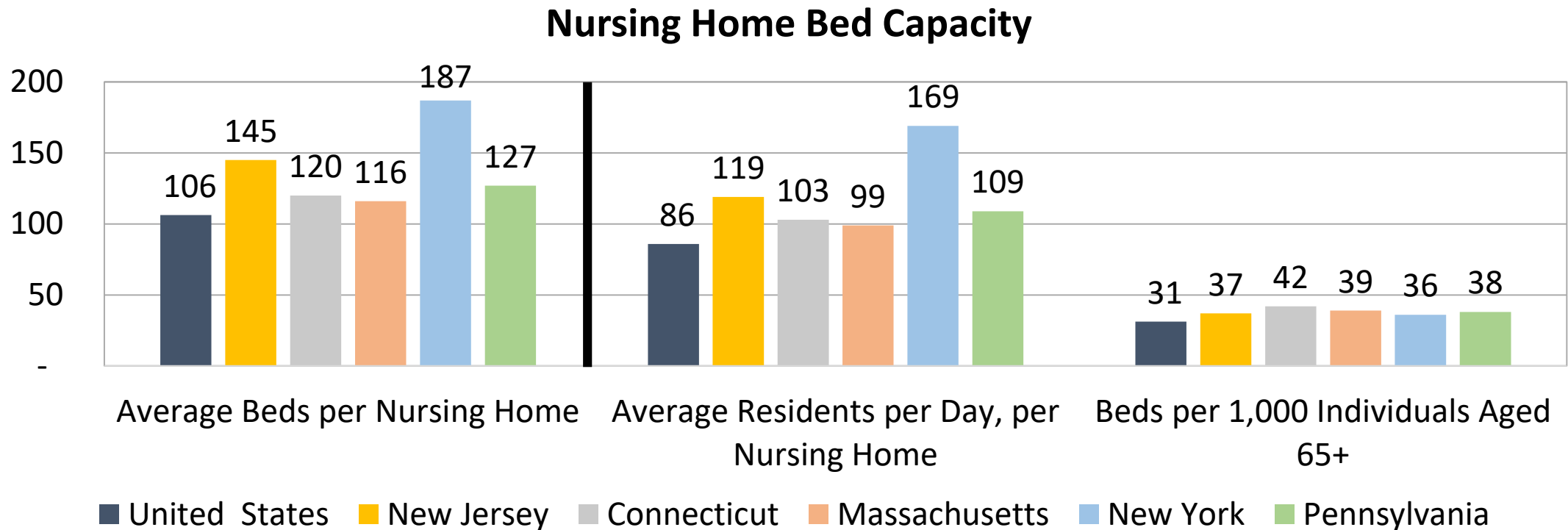
Source: Manatt analysis of Nursing Home Compare data as of May 12, 2020. Based on standard surveys reported 2016 to 2019. Analysis excludes 7 hospitals where daily average resident totals are not available.

Prior to COVID-19, New Jersey’s nursing home occupancy rate was slightly higher than the national rate, but lower than in other states in the region.



Source: Manatt analysis of Nursing Home Compare data as of May 12, 2020. Based on standard surveys reported 2016 to 2019. Analysis excludes hospitals where daily average resident totals are not available.

Prior to COVID-19, New Jersey had comparable nursing home bed capacity to that of other states in the region.

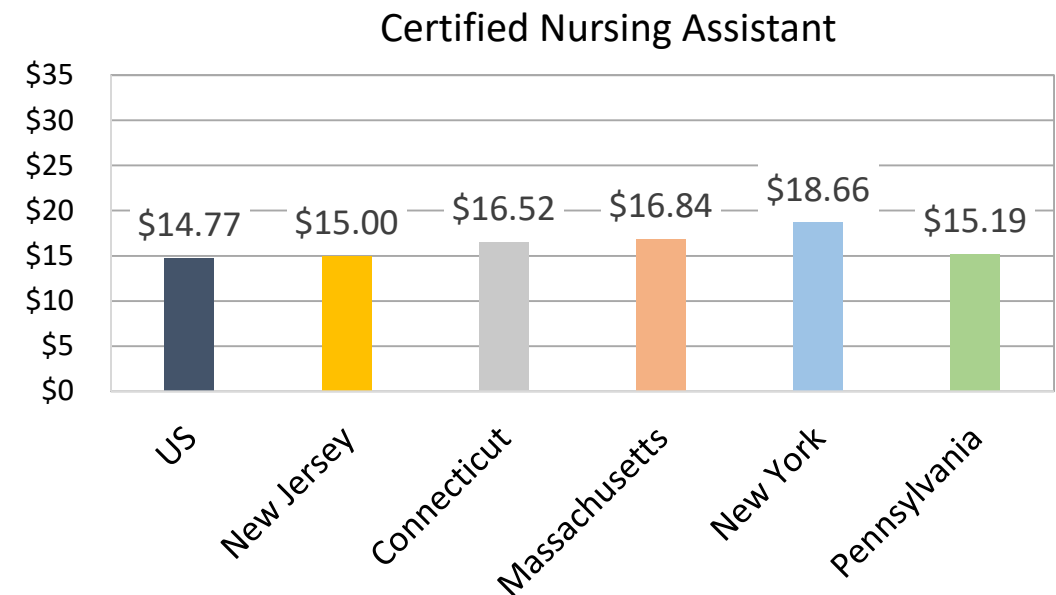
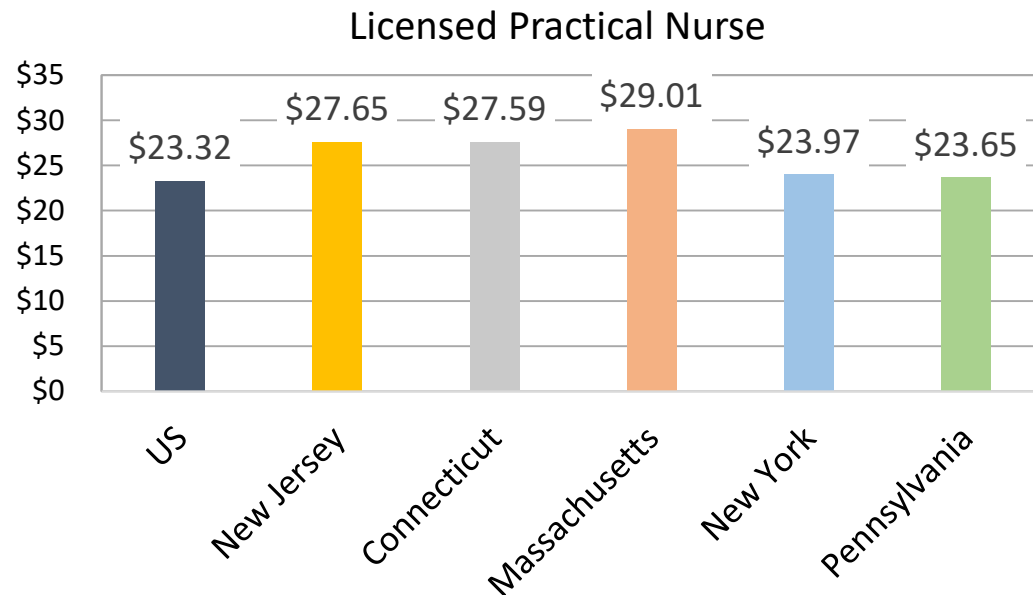


Source: Manatt analysis of Nursing Home Compare data as of May 12, 2020. Based on standard surveys reported 2016 to 2019. Analysis excludes hospitals where daily average resident totals are not available.

Nursing Home Staff Wages

New Jersey licensed practical nurses earn wages that are comparable to peers in neighboring states. New Jersey certified nursing assistants earn less than other states in the region.*

Hourly Mean Wage by State (2019)



Sources:

Occupational Employment Statistics Query System, Bureau of Labor Statistics, May 2019, <https://data.bls.gov/oes/#/home>

Occupational Outlook Handbook: Nursing Assistants, May 2019, bls.gov, <https://www.bls.gov/OOH/healthcare/nursing-assistants.htm>

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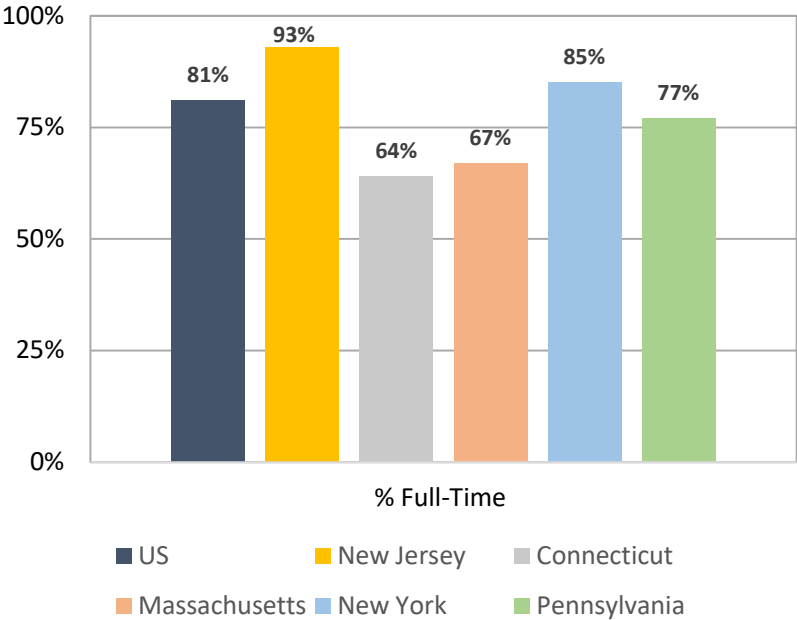
*Header revised for clarity on 6/4/20.

Nursing Home Employment Status and Health Insurance Coverage Rates

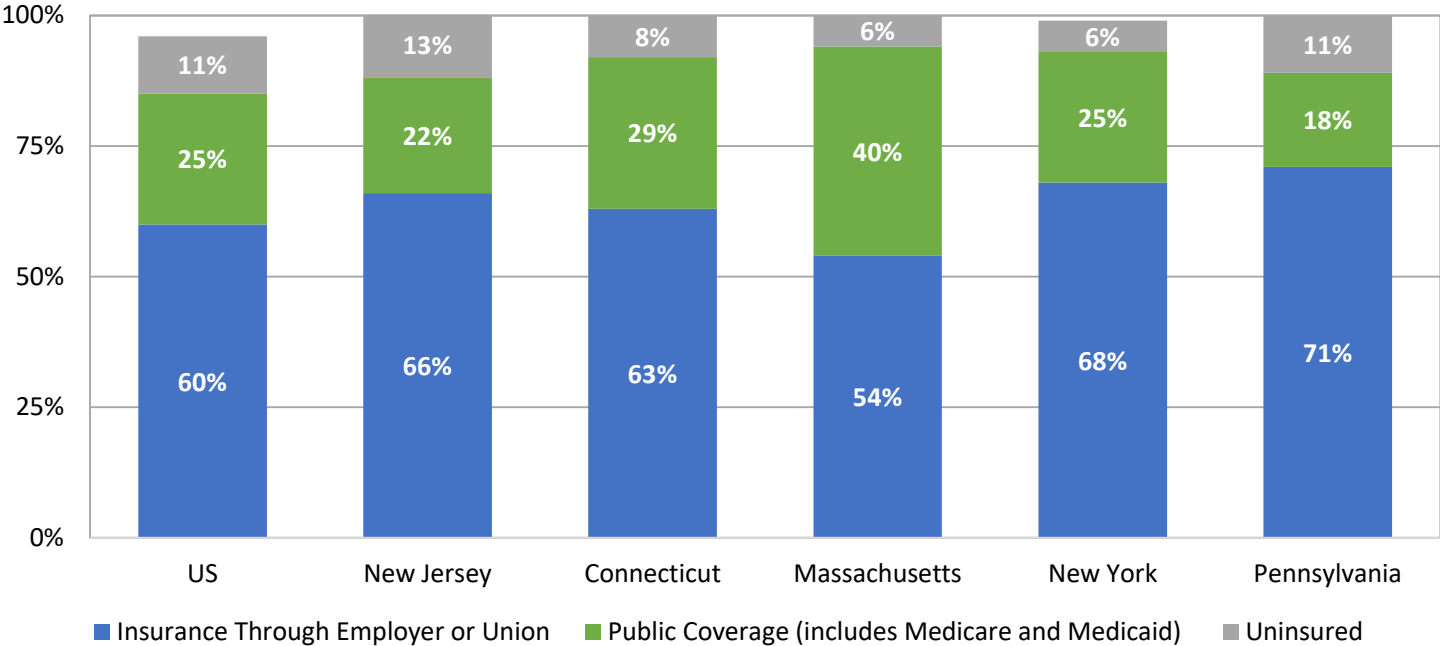


A higher proportion of New Jersey nursing home employees are full time compared to other states in the region and the nation, yet 13% are uninsured.

Nursing Home Employment Status (2018)



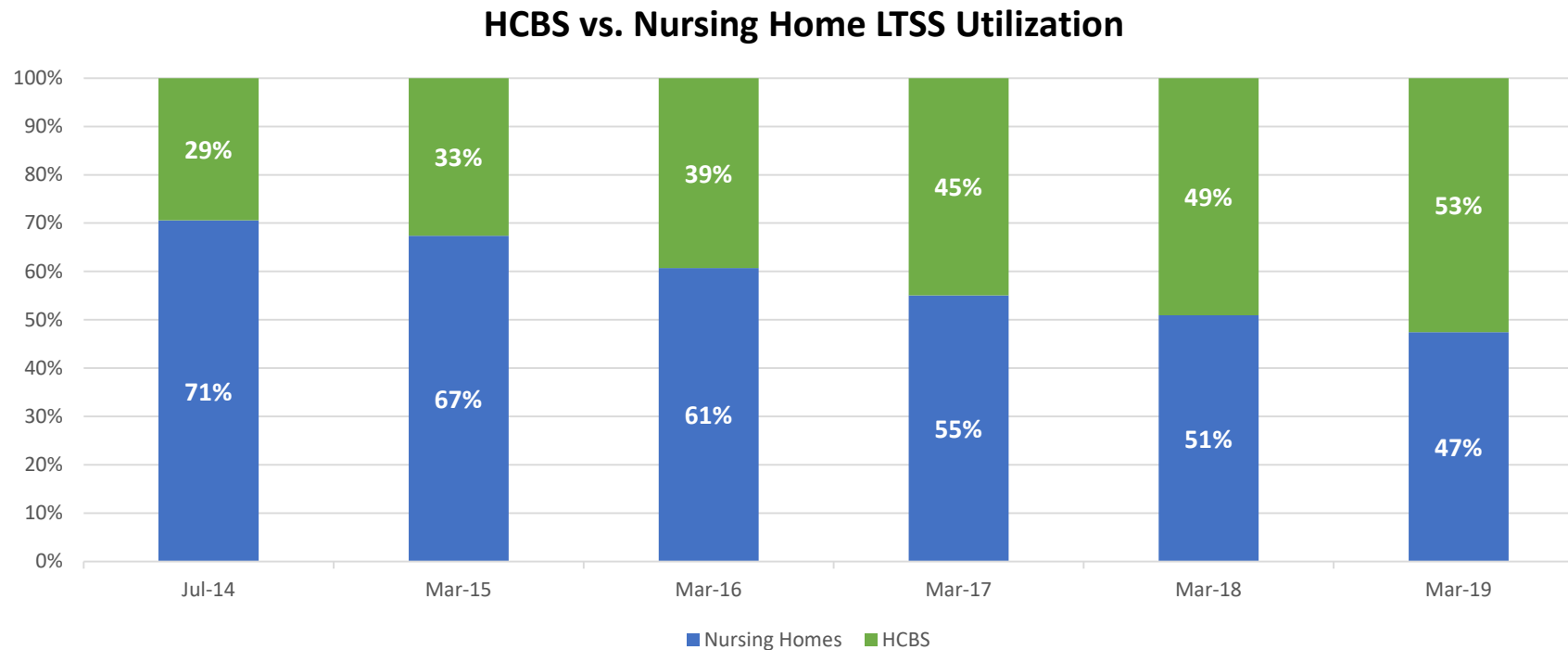
Health Insurance Coverage Source (2017)



Note: Further investigation is recommended on cost of living and sufficiency of wages for full-time and part-time equivalents. Components may not sum to 100 percent due to rounding.

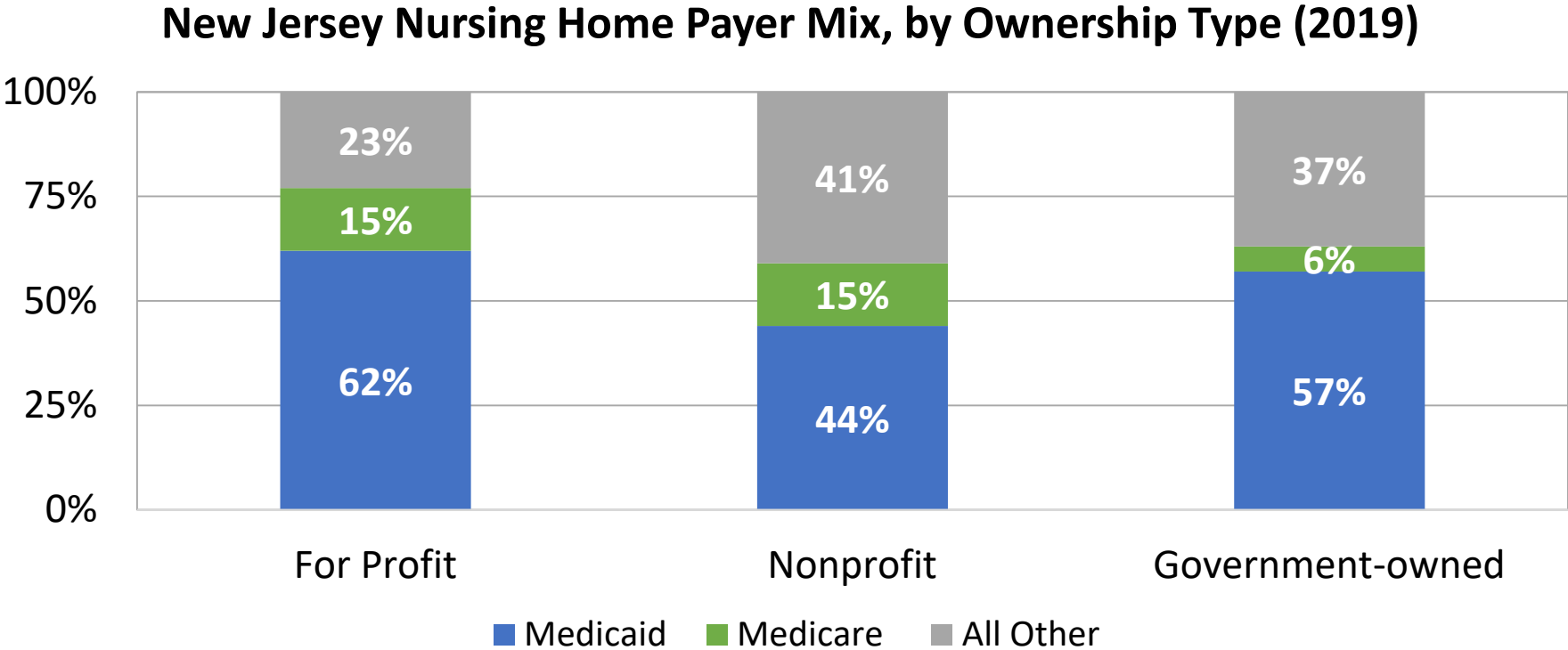
Source: Workforce Data Center, PHI, <https://phinational.org/policy-research/workforce-data-center/>

Initiatives to increase the utilization of HCBS in New Jersey's Medicaid program continue to be a high priority. Substantial progress has been made in recent years to grow utilization.



Source: Long Term Care Trend, NJ Family Care, http://www.njfamilycare.org/analytics/LTC_trend.html

Medicaid is the largest payer across all nursing home ownership types in New Jersey, although it provides a substantially smaller share of reimbursement for nonprofit facilities as compared to other ownership types.



Source: New Jersey Nursing Home Profile, 2019, njha.com, <http://www.njha.com/media/1190328/snf-2019-report.pdf>

APPENDIX F. ANALYSES OF COVID-19 BY REGION, QUALITY RATINGS, STAFFING, AND OWNERSHIP TYPE

Parameters of NJ Nursing Home Analysis

- On May 22, Manatt completed an analysis of COVID-19 cases and deaths in New Jersey nursing homes by region, quality ratings, staffing, and ownership using the following data:
 - Nursing Home Compare data (<https://www.medicare.gov/nursinghomecompare/search.html> – accessed, May 12, 2020)
 - U.S. Census data (<https://data.census.gov/cedsci/> - accessed, May 12, 2020)
 - New Jersey LTC COVID-19 infection and death data (<https://www.state.nj.us/health/healthfacilities/documents/LTCFacilitiesOutbreaksList.pdf> - accessed, May 12, 2020)
 - New Jersey COVID-19 dashboard data (https://www.nj.gov/health/cd/topics/covid2019_dashboard.shtml – accessed, May 22, 2020)
- Regional analyses included in this report were conducted based upon the State's five historic Medical Coordination Center regions, which are defined by county as shown below.

North West

- Passaic
- Morris
- Sussex
- Warren

Central East

- Middlesex
- Monmouth
- Ocean
- Union

South

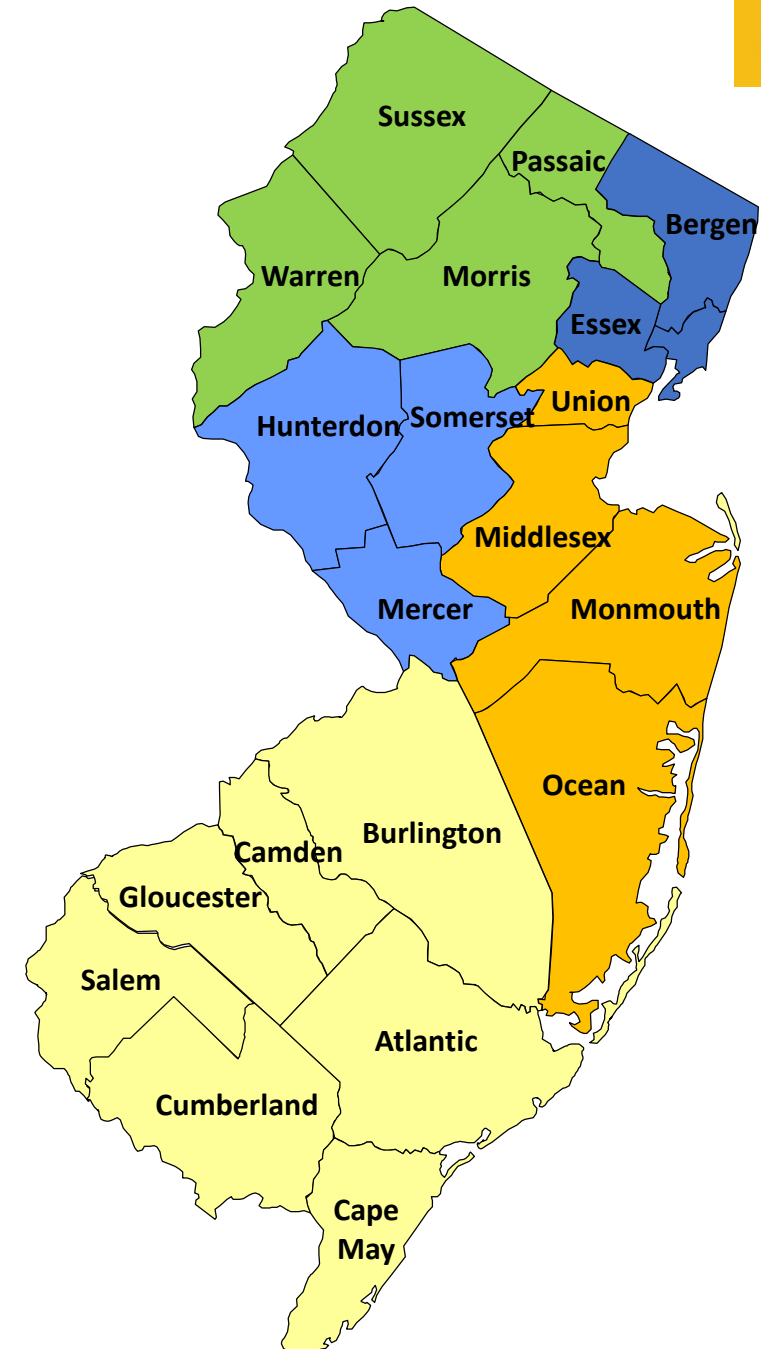
- Atlantic
- Burlington
- Camden
- Cape May
- Cumberland
- Gloucester
- Salem

North East

- Bergen
- Essex
- Hudson

Central West

- Hunterdon
- Mercer
- Somerset



Total and Nursing Home COVID-19 Cases by Region

Geography	Population (2019 Census)	Total Cases	Total Nursing Home Cases	Total Nursing Homes Licensed Beds
North East	2,403,000	52,643	4,604	13,020
North West	1,239,000	23,998	2,463	7,947
Central East	2,607,000	46,436	4,961	16,451
Central West	820,000	11,714	1,471	4,600
South	1,811,000	17,202	2,747	11,436
	Cases Per 1,000 People	Nursing Home Cases Per 1,000 Licensed Beds		
North East		21.91	353.61	
North West		19.37	309.93	
Central East		17.81	301.56	
Central West		14.29	319.78	
South		9.50	240.21	

Regions ranked in descending order by deaths per 1,000 people

Source: Manatt analysis of Nursing Home Compare data as of May 12th, 2020, U.S. Census data, Long Term Care Facility COVID-19 infections and deaths from New Jersey:

https://www.state.nj.us/health/healthfacilities/documents/LTC_Facilities_Outbreaks_List.pdf and the New Jersey COVID-19 dashboard https://www.nj.gov/health/cd/topics/covid2019_dashboard.shtml " as of May 22nd 2020

COVID-19 Cases and Deaths by Nursing Home Size

	Any Nursing Home	Total Licensed Beds		
		<= 125	126 to 174	175+
All Certified (Medicaid and/or Medicare) Nursing Homes	370	181	72	117
Among Nursing Homes With at Least 1 Confirmed Resident COVID-19 Infection				
Certified Nursing Homes	329	152	66	111
Total COVID-19 Cases (Residents Only)	16,246	5,261	3,225	7,760
Total COVID-19 Deaths (Residents Only)	4,317	1,354	900	2,063
Total Licensed Beds	49,525	14,357	9,619	25,549
COVID-19 Cases Per Licensed Bed	0.328	0.366	0.335	0.304
COVID-19 Deaths Per Licensed Bed	0.087	0.094	0.094	0.081

Source: Manatt analysis of Nursing Home Compare data as of May 12th, 2020, U.S. Census data, Long Term Care Facility COVID-19 infections and deaths from New Jersey: https://www.state.nj.us/health/healthfacilities/documents/LTC_Facilities_Outbreaks_List.pdf and the New Jersey COVID-19 dashboard https://www.nj.gov/health/cd/topics/covid2019_dashboard.shtml " as of May 22nd 2020

Note: Based on available data, strong, consistent, and reliable patterns between nursing home COVID-19 cases and deaths and nursing home size are not evident. Further investigation is recommended as more data becomes available, and data reliability increases.

COVID-19 Cases and Deaths by Nursing Home Ownership Status

	Any Nursing Home	Nursing Homes by Ownership Status		
		For Profit	Non Profit	Government
All Certified (Medicaid and/or Medicare) Nursing Homes	370	274	85	11
Among Nursing Homes With at Least 1 Confirmed Resident COVID-19 Infection				
Certified Nursing Homes	329	244	76	9
Total COVID-19 Cases (Residents Only)	16,246	12,822	2,616	808
Total COVID-19 Deaths (Residents Only)	4,317	3,327	734	256
Total Licensed Beds	49,525	38,083	8,672	2,770
COVID-19 Cases Per Licensed Bed	0.328	0.337	0.302	0.292
COVID-19 Deaths Per Licensed Bed	0.087	0.087	0.085	0.092

Source: Manatt analysis of Nursing Home Compare data as of May 12th, 2020, U.S. Census data, Long Term Care Facility COVID-19 infections and deaths from New Jersey: https://www.state.nj.us/health/healthfacilities/documents/LTC_Facilities_Outbreaks_List.pdf and the New Jersey COVID-19 dashboard https://www.nj.gov/health/cd/topics/covid2019_dashboard.shtml " as of May 22nd 2020

Note: Based on available data, strong, consistent, and reliable patterns between nursing home COVID-19 cases and deaths and ownership status are not evident. Further investigation is recommended as more data becomes available, and data reliability increases.

COVID-19 Cases and Deaths by Nursing Home Overall Star Rating

	Any Nursing Home	Nursing Homes by Nursing Home Compare Overall Star Rating		
		1 to 3*	4	5
All Certified (Medicaid and/or Medicare) Nursing Homes	370	151	81	138
Among Nursing Homes With at Least 1 Confirmed Resident COVID-19 Infection				
Certified Nursing Homes	329	138	70	121
Total COVID-19 Cases (Residents Only)	16,246	7,410	3,643	5,193
Total COVID-19 Deaths (Residents Only)	4,317	1,965	999	1,353
Total Licensed Beds	49,525	23,026	10,933	15,566
COVID-19 Cases Per Licensed Bed	0.328	0.322	0.333	0.334
COVID-19 Deaths Per Licensed Bed	0.087	0.085	0.091	0.087

*Note: Two facilities in New Jersey did not have a Overall Star Rating, and are grouped in the "1 to 3" category.?

Source: Manatt analysis of Nursing Home Compare data as of May 12th, 2020, U.S. Census data, Long Term Care Facility COVID-19 infections and deaths from New Jersey: https://www.state.nj.us/health/healthfacilities/documents/LTC_Facilities_Outbreaks_List.pdf and the New Jersey COVID-19 dashboard https://www.nj.gov/health/cd/topics/covid2019_dashboard.shtml " as of May 22nd 2020

COVID-19 Cases and Deaths by Nursing Home Quality Star Rating

	Any Nursing Home	Nursing Homes by Nursing Home Compare Quality Star Rating		
		1 to 3*	4	5
All Certified (Medicaid and/or Medicare) Nursing Homes	370	56	69	245
Among Nursing Homes With at Least 1 Confirmed Resident COVID-19 Infection				
Certified Nursing Homes	329	49	58	222
Total COVID-19 Cases (Residents Only)	16,246	2,832	2,749	10,665
Total COVID-19 Deaths (Residents Only)	4,317	724	662	2,931
Total Licensed Beds	49,525	8,343	7,951	33,231
COVID-19 Cases Per Licensed Bed	0.328	0.339	0.346	0.321
COVID-19 Deaths Per Licensed Bed	0.087	0.087	0.083	0.088

*Note: Two facilities in New Jersey did not have a Quality Star Rating, and are grouped in the "1 to 3" category.

Source: Manatt analysis of Nursing Home Compare data as of May 12th, 2020, U.S. Census data, Long Term Care Facility COVID-19 infections and deaths from New Jersey: https://www.state.nj.us/health/healthfacilities/documents/LTC_Facilities_Outbreaks_List.pdf and the New Jersey COVID-19 dashboard https://www.nj.gov/health/cd/topics/covid2019_dashboard.shtml as of May 22nd 2020

Note: Based on available data, strong, consistent, and reliable patterns between nursing home COVID-19 cases and deaths and nursing home Quality Star Ratings are not evident. Further investigation is recommended as more data becomes available, and data reliability increases.

COVID-19 Cases and Deaths by Nursing Home Staffing Star Rating

	Any Nursing Home	Nursing Homes by Nursing Home Compare Staffing Star Rating		
		1 to 3*	4	5
All Certified (Medicaid and/or Medicare) Nursing Homes	370	216	99	55
Among Nursing Homes With at Least 1 Confirmed Resident COVID-19 Infection				
Certified Nursing Homes	329	193	89	47
Total COVID-19 Cases (Residents Only)	16,246	10,804	4,103	1,339
Total COVID-19 Deaths (Residents Only)	4,317	2,786	1,131	400
Total Licensed Beds	49,525	31,387	13,283	4,855
COVID-19 Cases Per Licensed Bed	0.328	0.344	0.309	0.276
COVID-19 Deaths Per Licensed Bed	0.087	0.089	0.085	0.082

*Note: Two facilities in New Jersey did not have a Staffing Star Rating, and are grouped in the "1 to 3" category.

Source: Manatt analysis of Nursing Home Compare data as of May 12th, 2020, U.S. Census data, Long Term Care Facility COVID-19 infections and deaths from New Jersey: https://www.state.nj.us/health/healthfacilities/documents/LTC_Facilities_Outbreaks_List.pdf and the New Jersey COVID-19 dashboard https://www.nj.gov/health/cd/topics/covid2019_dashboard.shtml " as of May 22nd 2020

Note: Further investigation is recommended as more data becomes available, and data reliability increases.

COVID-19 Cases and Deaths by Nursing Home Health Deficiencies

	Any Nursing Home	Nursing Home Compare Deficiencies (2017-2020)		
		0	1 to 4	5+
All Certified (Medicaid and/or Medicare) Nursing Homes	370	4	44	322
Among Nursing Homes With at Least 1 Confirmed Resident COVID-19 Infection				
Certified Nursing Homes	329	2	36	291
Total COVID-19 Cases (Residents Only)	16,246	55	1,383	14,808
Total COVID-19 Deaths (Residents Only)	4,317	12	319	3,986
Total Licensed Beds	49,525	167	4,012	45,346
COVID-19 Cases Per Licensed Bed	0.328	0.329	0.345	0.327
COVID-19 Deaths Per Licensed Bed	0.087	0.072	0.080	0.088

Source: Manatt analysis of Nursing Home Compare data as of May 12th, 2020, U.S. Census data, Long Term Care Facility COVID-19 infections and deaths from New Jersey: https://www.state.nj.us/health/healthfacilities/documents/LTC_Facilities_Outbreaks_List.pdf and the New Jersey COVID-19 dashboard https://www.nj.gov/health/cd/topics/covid2019_dashboard.shtml " as of May 22nd 2020

Note: Based on available data, strong, consistent, and reliable patterns between nursing home COVID-19 cases and deaths and nursing home health deficiencies are not evident. Further investigation is recommended as more data becomes available, and data reliability increases.

COVID-19 Cases and Deaths by Nursing Home Infection-Related Deficiencies

	Any Nursing Home	Nursing Home Compare Infection Deficiencies (2017-2020)		
		0	1	2+
All Certified (Medicaid and/or Medicare) Nursing Homes	370	107	154	109
Among Nursing Homes With at Least 1 Confirmed Resident COVID-19 Infection				
Certified Nursing Homes	329	87	139	103
Total COVID-19 Cases (Residents Only)	16,246	4,181	6,532	5,533
Total COVID-19 Deaths (Residents Only)	4,317	1,102	1,828	1,387
Total Licensed Beds	49,525	11,751	21,086	16,688
COVID-19 Cases Per Licensed Bed	0.328	0.356	0.310	0.332
COVID-19 Deaths Per Licensed Bed	0.087	0.094	0.087	0.083

Source: Manatt analysis of Nursing Home Compare data as of May 12th, 2020, U.S. Census data, Long Term Care Facility COVID-19 infections and deaths from New Jersey: https://www.state.nj.us/health/healthfacilities/documents/LTC_Facilities_Outbreaks_List.pdf and the New Jersey COVID-19 dashboard https://www.nj.gov/health/cd/topics/covid2019_dashboard.shtml " as of May 22nd 2020

Note: Based on available data, strong, consistent, and reliable patterns between nursing home COVID-19 cases and deaths and nursing home infection-related deficiencies are not evident. Further investigation is recommended as more data becomes available, and data reliability increases.

COVID-19 Cases and Deaths by Nursing Home Staffing-Related Health Deficiencies

	Any Nursing Home	Nursing Home Compare Staffing Deficiencies (2017-2020)		
		0	1	2+
All Certified (Medicaid and/or Medicare) Nursing Homes	370	269	76	25
Among Nursing Homes With at Least 1 Confirmed Resident COVID-19 Infection				
Certified Nursing Homes	329	239	68	22
Total COVID-19 Cases (Residents Only)	16,246	11,497	3,514	1,235
Total COVID-19 Deaths (Residents Only)	4,317	3,020	964	333
Total Licensed Beds	49,525	35,500	10,542	3,483
COVID-19 Cases Per Licensed Bed	0.328	0.324	0.333	0.355
COVID-19 Deaths Per Licensed Bed	0.087	0.085	0.091	0.096

Source: Manatt analysis of Nursing Home Compare data as of May 12th, 2020, U.S. Census data, Long Term Care Facility COVID-19 infections and deaths from New Jersey: https://www.state.nj.us/health/healthfacilities/documents/LTC_Facilities_Outbreaks_List.pdf and the New Jersey COVID-19 dashboard https://www.nj.gov/health/cd/topics/covid2019_dashboard.shtml " as of May 22nd 2020

Note: Further investigation is recommended as more data becomes available, and data reliability increases.

COVID-19 Cases and Deaths by Nursing Home Staffing Hours

	Any Nursing Home	Nursing Home Compare Adjusted Total Nursing Home Staffing Hours per Resident per Day		
		<=3.33	3.34 to 3.84	3.85+
All Certified (Medicaid and/or Medicare) Nursing Homes	370	73	156	141
Among Nursing Homes With at Least 1 Confirmed Resident COVID-19 Infection				
Certified Nursing Homes	329	65	138	126
Total COVID-19 Cases (Residents Only)	16,246	3,617	7,834	4,795
Total COVID-19 Deaths (Residents Only)	4,317	926	2,058	1,333
Total Licensed Beds	49,525	10,554	22,067	16,904
COVID-19 Cases Per Licensed Bed	0.328	0.343	0.355	0.284
COVID-19 Deaths Per Licensed Bed	0.087	0.088	0.093	0.079

Note: Nursing home staffing hours only includes nurse staffing hours (registered nurse, licensed practical nurse, and nurse aids), but does not include other types of nursing home staff including clerical and housekeeping staff.

Source: Manatt analysis of Nursing Home Compare data as of May 12th, 2020, U.S. Census data, Long Term Care Facility COVID-19 infections and deaths from New Jersey:

https://www.state.nj.us/health/healthfacilities/documents/LTC_Facilities_Outbreaks_List.pdf and the New Jersey COVID-19 dashboard

https://www.nj.gov/health/cd/topics/covid2019_dashboard.shtml " as of May 22nd 2020

Note: Based on available data, strong, consistent, and reliable patterns between nursing home COVID-19 cases and deaths and nursing home staffing hours are not evident. Further investigation is recommended as more data becomes available, and data reliability increases.

Recommendations for Future Quantitative Analysis

The following data would support additional in-depth research efforts:

- Timely, complete and verified geographic and nursing home infection and death time-series death data.
- Detailed information on LTC facility layout including configuration and age of facilities (e.g., number of homes and proportion of beds in 2, 3, and 4 resident rooms, unit size).
- Detailed information on special populations (e.g., dementia care units) and patient acuity levels.
- Additional ownership information. The majority of New Jersey LTC facilities (74%) are under for-profit ownership. Manatt did not identify a strong correlation between ownership type (for profit, not-for-profit) and LTC COVID-19 cases or deaths, though overall trends may mask significant differences among specific ownership scenarios and parent company owners, data which were not publicly available.

In addition, New Jersey might consider deeper-dive research focusing on identifying the strategies most successful in:

- Reducing nursing home exposure to COVID-19.
- Slowing the rate of COVID-19 transmission among nursing home residents.
- Reducing death rates for COVID-19 infected residents with similar health profiles and acuity.

APPENDIX G. OTHER STATE AND LOCAL RESPONSES

Selection of State and Local Responses



California: As of the middle of May, only three of the 2,100 residents living in California’s eight veterans homes were confirmed positive for COVID-19. News reports attribute the low infection rate to leadership, planning and infection control. The Secretary of California’s Department of Veterans Affairs and the Director of Long-Term Care were meeting regularly with facility directors by mid-February and implementing a 38-step plan that included: update each facility’s emergency operation plans, ensure facilities have enough PPE, and undertake infection control measures such as using disposable dinnerware and disinfecting common areas every 30 minutes. Pre-COVID-19 factors also contributed to the low infection rate: electronic records are used, procedures are standardized across all facilities in the system, workforce has paid sick leave, and staff physicians are on-site daily.



Michigan: Established “regional hubs” designated by the state Department of Health and Human Services to treat individuals from congregate care settings who are affected by COVID-19 but do not require hospital-level care. There are approximately 19 hubs serving nearly 300 patients, each with enhanced daily reporting requirements. Michigan also activated an infection prevention resource and assessment team (iPRAT) to provide training to local health departments and facilities; review facilities’ infection control procedures and training protocols; assist with remote contact tracing; and provide remote facilitation of the CDC’s Tele-ICAR tool.



North Carolina: The Division of Public Health and North Carolina Area Health Education Centers (AHEC) provide reoccurring virtual trainings and updates to more than 2,000 LTC workers. In addition, sessions provide a Q&A opportunity between providers and the state. North Carolina worked with AHEC to push out information to providers on testing, PPE, and infection control.



Paterson, NJ: Contract tracers have traced approximately 90% of the city’s 6,200 COVID-19 cases. Prior to COVID-19, the Paterson Board of Health (BOH) had two disease detectives on staff, but an additional two dozen BOH employees had been trained in communicable disease investigation last year using a state grant. The contract tracing team now includes 50 of BOH’s 60 employees. Contact tracers check in daily with all cases and their contacts to see how they are feeling and to monitor compliance with quarantine restrictions. New Jersey’s electronic communicable disease tracking system serves as the team’s master database.

The Green House Project is a relatively new nursing home model that emphasizes resident autonomy and highly personalized care teams in a setting that looks and feels less like an institution and more like a home.

- The [Green House Project](#) model was developed by a geriatrician in the early 2000s, with support from the Robert Wood Johnson Foundation. Key elements of the model include:
 - Residents live in self-contained small home-like settings. Medical equipment is tucked away in wall closets to maintain the home-like feel.
 - Each home has a low staff ratios and staff receive advanced training.
 - Nursing assistants manage residents' care, with support from nurses and therapists. Unlike the traditional nursing home model, there are not additional supervisory or administrative layers.
- The first Green House was opened in 2003 in Mississippi. In 2010, the first Green House home for short-term rehab was opened and in 2011, the first Green House homes for veterans opened.
- There are two Green House homes in New Jersey: Morris Hall Meadows in Lawrenceville and Green Hill in West Orange.
- There are now nearly 300 Green House homes in 32 states. **As of mid-May, only 8 of 243 reporting homes have a COVID-19 case.**
- The Green House Project works with organizations, including developers and providers, to build Green House homes by connecting them to an experienced peer network, and providing consultation services on building a business case, financing, addressing regulatory hurdles, and designing and constructing the homes.
- Financing options for building Green House homes include grants, social impact investments, and tax credits for Green House homes in low-income communities.

"When you know somebody really well, you could pick up atypical behavior. You know someone isn't eating as much as they normally eat because you prepare the meals...You can get testing faster, make a diagnosis and move the patient out to the [Covid-19-positive] cohort of units that we have."

-Dr. Jeffrey Farber, CEO of the New Jewish Home, discussing the advantages of the Green House Project during the pandemic

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