KANSAS ADVOCATES for BETTER CARE
making elder care better every day

July 6, 2020

Seema Verma, Administrator

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attn: CMS-5531-IFC

P.O. Box 8010

Baltimore, MD 21244

RE: Medicare and Medicaid Programs, Basic Health Program and Exchanges;

Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program CMS-5531-IFC

Submitted electronically: http://www.regulations.gov

Dear Administrator Verma:

Kansas Advocates for Better Care (KABC) is a statewide not-for-profit organization whose mission is to improve the quality of long- term care for elders in nursing and assisted facilities as well as in their own homes. KABC is not a provider of government funded services. For 45 years KABC's role has been as a resource and advocate for older adults and families and as a resource to policy makers on aging and quality care issues. KABC provides consumer education information and tracks and reports on quality care performance issues.

Our work includes monitoring policy and legislation affecting care and services for older adults and persons with disabilities. Our advocacy priorities at the state level include increasing nurse staffing levels to the proven standard of 4.1 hours per resident per day, reducing the use of antipsychotic drugs among nursing home residents with dementia, State compliance with required annual nursing home inspection timelines and protecting the rights of residents and older adults.

At the same time, we serve as a resource for family members seeking help in making decisions with their loved ones. We see and hear directly from older adults and their families on the impact of policies and legislation on Kansans.

The COVID-19 pandemic has laid bare the deficits of the long-term care system. Since the pandemic began, we have heard heart-breaking, deeply distressing stories of the virus' impact on

older adults in nursing facilities and adult care homes. More than ever it is clear that significant reforms and higher levels of accountability and transparency are needed in long-term care. We have an opportunity now to improve the quality of long-term care; to use what we have learned to address the deficits and reform system. We appreciate the efforts of CMS to work toward improvements with this Interim Final Rule but agree with the recommendations from The National Consumer Voice for Quality Long Term Care that will strengthen the rule and address the gaps in the reporting requirements that make it difficult to gain a true picture of what is happening within long term care facilities.

While we agree with all of the Consumer Voice's recommendations, we would like to highlight those that are of particular importance for Kansans.

Data tracking and monitoring

We appreciate the steps taken by CMS requiring facilities to report COVID-19 data under **§483.80 Infection Control**. This critical data will permit facilities along with local, state, and national officials to monitor the spread of COVID- 19. In addition, it will allow nursing home residents, their representatives and families, staff, and the public to know the current status of COVID-19 in any Medicare and/or Medicaid-funded facility. Residents and staff need this information because it directly impacts the place where they live or work. Families need it to monitor the health and safety of their loved ones. The data also enables both current and prospective residents and families to make informed decisions regarding their options for care.

A lack of public reporting and tracking has hindered Kansas' ability to address the needs of older adults in adult care settings. Until the June 4th guidance from CMS required it, there was no public health reporting that identified the nursing facilities with COVID cases. There still is none for assisted living facilities, residential care facilities and Home Plus facilities. Without it, older adults and their families lack the critical information they deserve and need to consider a facility placement for rehabilitation or long-term care. As we go forward, it is imperative for everyone to have transparent, timely and publicly available data to identify the best interventions and practices and determine where resources and assistance are needed.

§483.60 Infection Control Reporting

We agree with the recommendations made by The National Consumer Voice for Quality Long-Term Care to strengthen gaps in the reporting requirements. We believe these recommendations will give families, policymakers, advocates and the public a more complete picture of the care provided in facilities.
To get a more in-depth, comprehensive understanding of the extent and impact of COVID-19 on nursing home residents, we urge CMS to require that the following also be reported for residents and staff:

- **Race, ethnicity, sex, age, disability status, primary language, sexual orientation, gender identity, socio-economic status, urban/rural locations**.

In Kansas as nationally COVID 19 infections and death, are falling harder on some communities based upon demographic characteristics. COVID-19 is having a disproportionate impact on communities of color. A study from Yale found that black people were 3.5 times more likely to die from COVID-19 when compared with whites.

Tracking demographic data for those who have been infected or hospitalized, or who have recovered or died from COVID-19 helps identify groups that may have a higher likelihood of getting sick and experiencing severe illness from COVID-19 as the pandemic progresses. It can help state, tribal and local agencies, health systems, hospitals, and health care providers invest in and direct resources to provide access to testing, health care, and social services for diverse populations with different needs. Finally, it helps in the prioritization and distribution of resources.

- **Number of hospitalizations.** Reports of age and disability discrimination in care have been made during the pandemic. Collecting the number of hospitalizations, in addition to demographic data of individuals sent to the hospital, would assist in determining if this is a problem, and if so, the extent of the problem.

- **Number of residents and staff who have recovered from COVID-19.** Recovery data can help us gain a better understanding of what factors contribute to survival.

We also request CMS define "suspected" cases in the rule, using the definition provided in the National Health Safety Network (NHSN) system, Instructions for Completion of the COVID-19 Long-term Care Facility Resident Impact and Facility Capacity From (CDC 57.114.0). We also ask the regulations specifically state that deaths of residents who have been transferred to the hospital or elsewhere be reported. We acknowledge and are glad that CMS addressed the inclusion of deaths occurring outside the facility in its May 6, 2020 FAQs (question 11). For consistent reporting we believe those deaths need to be reported.

Infection control in nursing facilities was a critical indicator of quality care before the onset of COVID-19. A May 20, 2020 GAO inquiry shows investigators found a recurring pattern of non-compliance by nursing homes in meeting health safety regulations to prevent and control the spread of infection ahead of COVID. (https://www.gao.gov/assets/710/707069.pdf)

As a result, the GAO investigation found more than 25,000 deaths of nursing home residents from COVID 19 in May. The Kaiser Family Foundation reported the number of deaths on June 4 had climbed to 43,000 in nursing homes. (https://www.kff.org/health-costs/issue-brief/state-data-and-policy-actions-to-address- coronavirus/)

During this pandemic we have learned that the corona virus targets those with multiple chronic conditions which is true for the overwhelming majority of older adults who reside in adult care facilities. Before the virus hit, we knew:

- the environment in nursing and assisted facilities keeps elders in close proximity to one another, including shared rooms.

- many adult care facilities routinely operated with less staff than is safe for elders who reside there. Few Kansas nursing facilities provide safe staffing minimums of 4.1 hours per resident per day (as defined by the federal government in 2001).

- 82% of nursing homes inspected had at least one deficiency related to infection control and prevention (2013-2019).

- Nearly half the facilities were cited for non-compliance in multiple consecutive years. This included facilities being cited for staff not washing their hands, or failing to implement preventive measures during infectious disease outbreaks such as isolating sick residents and using masks and other personal protective equipment to control the spread of infection.

- **77% (261 of 341) Kansas facilities were cited for non-compliance with infection control practices which in turn deprived residents of basic protections from infection.**

§483.80(g)(1) (iii) Personal Protective Equipment and Hand Hygiene Supplies

Again, clarification is needed regarding the types of personal protective equipment (PPE) that should be used in long term care settings. An integral part of infection prevention and control is having personal protective equipment (PPE) available for staff, residents and visitors. Nursing homes are required and reimbursed to have sufficient staffing, personal protective equipment and supplies to meet the needs of their residents at all times. They are legally and morally obligated to implement procedures that protect residents from infection and its spread. Instead, we continue to hear reports from staff and families that facilities are not providing appropriate PPE, some forbid staff from wearing it, some require staff to share gowns, and in some cases lock the PPE away so it can't be used.

The recommendations proposed will also protect frontline workers, many of whom have gone above and beyond in providing care while putting their own health and safety on the line.

§483.80 (g)(1) (vii) Staffing Shortages

Inadequate staffing requirements for nursing homes have been a long-standing problem in Kansas. In large part, staffing shortages have contributed to Kansas being among the worst states for the overuse and inappropriate use of antipsychotic drugs among nursing home residents with dementia.

Understaffing dangerously increases workload for nurse aides, leaving inadequate time to meet the needs of many elders and to take the precautions of simple hand washing which is considered primary for preventing and stopping the spread of COVID-19.

We support the proposed requirement that staffing information be reported to the CDC. However, we are concerned about use of the term "staffing shortages." Although the NHSN

instructions discuss what is meant by staffing shortages, the Interim Final Rule does not include a definition. The NHSN definition should be spelled out in the rule.

Moreover, because there is currently no federal requirement for minimum staffing standards, it is difficult for facilities to determine that they are short staffed unless they are egregiously so. Requiring facilities to provide daily staffing levels by shift would address this issue. We note that facilities are already mandated to post this information inside the facility so reporting it to CMS should not be burdensome.

Additionally, the proposed staffing requirement fails to indicate who is included in the term "staff." Once again, this information is included in the NHSN instructions, but not in the rule. We recommend that the list of staff used in the NHSN be incorporated into the Interim Final Rule.

Finally, due to a waiver of certain nurse aide requirements, there are now individuals employed as nursing assistants who have not met training and certification requirements. To understand the extent to which facilities are using these temporary nursing assistants, facilities should be required to report the number of this new type of employee.

Recommendation:
Add the following language:
(viii) **Staffing.**
(a) For the purposes of this rule, staffing is considered to be:
• Nursing Staff: registered nurse, licensed practical nurse, or vocational nurse.
• Clinical Staff: physician, physician assistant, or advanced practice nurse.
• Aide: certified nursing assistant, nurse aide, medication aide, or medication technician.
• Other staff or facility personnel: that are not included in the above categories, regardless of clinical responsibility or resident contact. These personnel may include, but are not limited to, environmental services, cook, dietary, pharmacists, pharmacy techs, activities director, care givers, wound care, physical therapy, shared staff, etc.

(b) Daily nurse staffing levels by shift (as required under 42 C.F.R. 483.35(g)(iii)).

(c) Number of temporary nursing assistants.

(d) Staffing shortages. A staffing shortage is determined by the facility based on its needs and internal policies for staffing ratios.

Public Reporting and Tracking

We strongly agree with all of the recommendations proposed by The Consumer Voice regarding requirements to provide information to the CDC for public posting **(§483.80(g)(2)**; informing residents, their residents, their representatives and their families **(§483.80(g)(3)**; proposed methods for providing information to families **(§483.80(g)(4)**; informing the general public **(§483.80(g)(5**); penalties for failure to report **(§483.80(g)(6)** and reporting requirements for other settings **(§483.80(g)(7)**.

Individuals in adult care homes experienced the harshest impacts of COVID-19, nationally and in Kansas. Older adults living in nursing homes have been isolated without recourse. Elders in the tens of thousands have been denied the comfort of family, many have needlessly died alone. In four months, little has changed about this reality for elders.

Residents and families have been left in the dark. Residents were without knowledge of their own risk and unable to make informed care choices. Families were deprived of knowing the level of risk for a loved one in any given facility, they were left to anxiously awaiting information about COVID 19 status. Persons looking for rehab or short-term stays did not have the information they needed to make informed decisions about the risk a facility's COVID 19 status would have on their safety and well-being.

Reporting should be transparent, timely and easily accessed by residents, potential consumers, families, and the public.

The rule fails to require retroactive reporting to January 1, 2020. The fact that some facilities do and others do not has created data that is inaccurate or unreliable and of little use to analyze COVID 19's real impact on nursing facilities and residents.

Recommendation:
(2) Provide the information specified in paragraph (g)(1):
(i) Daily to the Centers for Disease Control and Prevention's National Healthcare Safety Network, the state survey agency, CMS, the State Long-Term Care Ombudsman Program, the Protection and Advocacy Agency, residents, their representatives and families, and staff.
(ii) Weekly for the period from January 1, 2020-May 8, 2020.
(iii) The information in (i) and (ii) must be posted publicly by CMS daily on the Nursing Home Compare website or any subsequent version of Nursing Home Compare to support protecting the health and safety of residents, personnel, and the public.

Thank you again for the opportunity to comment and your consideration of our recommendations.

Mitzi E. McFatrich, Executive Director - On behalf of Board of Directors and Members
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