COMMENTARY

Reimagining Nursing Homes in the Wake of COVID-19

Terry T. Fulmer, The John A. Hartford Foundation; **Christopher F. Koller,** Milbank Memorial Fund; and **John W. Rowe,** Columbia University Mailman School of Public Health

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The COVID-19 pandemic has disproportionately affected nursing home residents. According to a *New York Times* database, nursing homes account for 8 percent of cases and 41 percent of COVID-19-related deaths nationwide [1]. While the clinical status of these patients is the major determinant of risk, debate continues on the relative importance of locale, the race and socioeconomic status of patients, facility size state regulations, payer mix, and ownership status. Nonetheless there is agreement that, in general, America's nursing homes are not designed, operated, or funded to deal effectively with infectious disease epidemics, and their staff are often too few in number and inadequately paid, protected, and trained [2]. While knowledge related to caring for residents during COVID-19 accrues, nursing homes will continue to apply multiple strategies to meet the many different requirements for care of their older residents. These challenges may be better met, however, with targeted strategies better suited to the needs of specific subsets of nursing home residents.

History

The earliest nursing homes in America can be traced to a tradition in England where care was provided in almshouses to those who were orphaned, poor, or physically or mentally disabled and had no other means to be sheltered, fed, or cared for [3]. These original nursing homes existed in much the same fashion until 1935 with the passage of the Social Security Act (SSA) whose "old age assistance programs" made funds available to states to care for older adults who were destitute [4]. In the 1950s, the SSA was amended to pay nursing homes directly for medical care, instead of the beneficiaries. In 1965, Medicare and Medicaid were passed as amendments to the SSA, and Medicare was designed to focus on acute care only with Medicaid covering long-term care in institutions, but not care in the home. This 1965 amendment created a cultural and economic preference for institutional long-term care. The majority of nursing homes constructed as a result were with a distinctly institutional design—with double occupancy rooms—which has been an especially challenging factor during the COVID-19 pandemic.

It was not until the 1970s that home- and community-based long-term care services received financial support under the SSA as an optional Medicaid benefit. With each passing decade, amendments were made to reflect the changing demographics of the country with nearly a doubling of the life expectancy of Americans from 1900 to 2000.

Current Status

There are 15,505 nursing homes in the United States with approximately 1.3 million residents; 84 percent of residents are over age 65, and two thirds are women. More than a third experience dementia, and most have significant disabilities. Approximately 69 percent of nursing homes are for-profit [5]. Over 15 million nursing assistants (CNAs) are employed in the setting, most of whom are under 55 years old and female, have a high school education or less, and have an income of $30,000 dollars or less annually [6]. According to the Bureau of Labor Statistics, there will be an annual growth rate of 9 percent for CNAs over the next decade, which is faster than average [7].

This low-paid, poorly trained workforce must address a great heterogeneity of need among nursing home residents. 43 percent of nursing home residents will stay less than 100 days—the point at which Medicare nursing home benefits generally end. These short-stay patients receive skilled nursing care, generally for either rehabilitation services after hospitalization or for palliative and hospice care at the end of life.

Most adults who reside in nursing homes for long periods have exhausted personal assets and rely on

Medicaid for payment. Most residents have multiple comorbidities, are frail and disabled, and often experience dementia. Clinical syndromes such as incontinence, cognitive impairment, delirium, and inability to walk or eat independently are frequent harbingers of nursing home placement [8].

Even prior to COVID-19, the quality of nursing home care has long been a critical issue. The Centers for Medicare and Medicaid Services (CMS) initiated a Nursing Home Compare website in 1998 designed to help the public monitor clinical quality of nursing homes by providing nursing home performance measures and currently uses a five-star rating system. As of 2015, approximately 39 percent of US nursing homes had overall low ratings (one or two stars) [9].

The Way Forward

The COVID-19 disaster presents an opportunity to reimagine the role of nursing homes. To begin with, the physical design and operating model of these nursing homes must be revised to accommodate the need for patient isolation, social distancing, reduction in the cycling of staff and patients from the community to the facility, and staff protection during times when infectious diseases are rampant. Given these epidemic-related considerations, "unpacking strategies" should also be considered to improve quality of care by better matching services provided with the needs of specific patient groups.

In such an approach, relatively homogenous subsets of current and future nursing home populations would be matched to other care sites. Nursing home residents requiring hospice care could be relocated to in-patient or at-home hospice programs. Those with "pure memory impairment" who are relatively well otherwise could be placed in the now common "memory centers" that are specifically designed and operated to manage the needs of such patients.

Many of the long-stay patients with multiple comorbidities might be better served in smaller facilities, such as Green Houses [10], which often have only 18 beds and offer high-quality care. However, this model is financially challenging especially for for-profit facilities, which tend to be large to gain efficiency. A substantially strengthened PACE (Program for the All-Inclusive Care of the Elderly) program [11]—a capitated benefit that provides comprehensive medical and social services in an adult day health center supplemented by in-home and referral services—and better-funded traditional home care programs could also help take up patients who would have been in nursing homes, depending on their needs and preferences.

A critical question is how best to manage post-hospitalization short-stay rehabilitation patients. Some have called for the return of extended care wings from the 1960s and 1970s that are contiguous with acute care facilities and can offer equal staffing, supplies, and equipment for those who need short-term rehabilitation [12]. There are obvious advantages to such a strategy, including the use of beds that may become empty as hospital census continues to decline, and the proximity of such "extended care units" to the patient's primary care and specialty providers during the post-acute phase of illness. In addition, positive financial performance under bundled care, an increasingly important aspect of payment reform, especially for hip fracture recovery and congestive heart failure care, appears largely determined by the control of the post-acute phase of the episode [13].

However, the design, staffing, delivery, and financing of post-acute care is very different from acute care, and hospitals may not be able to effectively manage this population. Many hospitals may not be able to afford the investment required to establish such extended care units. Most US hospitals are nonprofits with slim operating margins close to 1–2 percent and limited sources of capital to invest in new facilities and programs.

As the primary financiers for short- and long-term nursing home stays respectively, the payment rules of Medicare and Medicaid will play crucial roles in realizing a new vision for the appropriate services and settings for the care nursing homes currently provide.

Despite these hurdles, the authors of this paper argue that the inadequacy of the current system has been put on display, and it is time to develop new strategies to better match the care provided with the needs of the varied subsets of the institutional long-term care population. Matching patients with specific needs with appropriate care models, increasing training and payment for the skilled nursing staff in these facilities, and interrogating the financing and payment structures that support these facilities seem to be obvious first steps in ensuring that the residents of nursing homes receive effective and efficient care.

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Author Information

Terry T. Fulmer is President of The John A. Hartford Foundation and a member of the National Academy of Medicine. **Christopher F. Koller** is President of the Milbank Memorial Fund. **John W. Rowe** is Julius B. Richmond Professor of Health Policy and Aging at the Columbia University Mailman School of Public Health and a member of the National Academy of Medicine.

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Correspondence

Questions or comments should be directed to Terry T. Fulmer at Terry.Fulmer@johnahartford.org.

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