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McKnight's
LONG-TERM CARE NEWS

Providers Make Gains Securing Liability Protections from COVID-related Suits

Written by: Danielle Brown

2/22/2021

While some providers across the United States are winning the fight to obtain COVID-19 liability protections for nursing homes, others are still struggling to secure immunity.

Indiana Gov. Eric Holcomb (R) on Thursday signed a proposal that gives businesses, including nursing homes, civil immunity from coronavirus-related lawsuits. Liability protections have been a key point for providers on the federal and state levels during the unprecedented public health crisis — with more than 20 states enacting legal cover for providers.

Proponents argued that the legislation would protect businesses and providers from frivolous lawsuits as they adapted during the pandemic, the Indy Star reported. Opponents, however, said the measure could discourage lawsuits that have nothing to do with the pandemic.

Holcomb noted that the measure does provide exceptions to civil immunity for "gross negligence or willful or wanton misconduct" and provides civil tort immunity for businesses that manufactured COVID-19 protection products.

The Indiana Health Care Association, in response to concerns, noted that the legislation is "specifically tailored to address actions that are in response to the pandemic or for COVID-19."

"Any alleged acts of negligence that are not in response to the pandemic or for COVID-19 will not be provided the heightened standard being considered under the proposals," the association said in a statement. "Further, neither proposal will prevent cases from being filed, allowing them to be considered based on the facts of each circumstance."

Nursing homes in Florida are still fighting to keep their protections and are closer to obtaining them after a state House committee passed a measure on Wednesday that would extend liability protections for healthcare providers.

The Florida Health Care Association argued in a statement that without COVID-19 liability protections, "predatory trial attorneys who use sue and settle tactics will divert those resources away from facilities that are still working to protect their residents and strengthen their front-line workforce."

"Our healthcare heroes are deserving of the liability protections that will ensure precious resources — both human and financial — remain where they should be: caring for Florida's elderly population," FHCA Executive Director Emmett Reed said.

McKnight's LONG-TERM CARE NEWS

Too Soon to Crown Home Care as Permanent Solution over SNFs, Executives Say

Written by: Danielle Brown

2/22/2021

It's "too early" to think that an increase in discharges to home health, as opposed to skilled nursing, will remain in place beyond the pandemic, according to executives with LTC Properties.

"We do have that expectation [that SNF occupancy will improve] as electives [surgeries] start to get scheduled here," Pam Kessler, the real estate investment trust's co-president, chief financial officer and secretary, said during a fourth-quarter earnings call Friday.

"I think it's too early to say whether home health has become a more permanent solution," she added.

Recent data has shown dramatic increases of patients being discharged into home health settings and sharp declines of discharges to SNFs, which has aided in record occupancy slides for the sector during the pandemic.

Kessler explained that in many cases elective surgeries have been postponed for residents who will require more complex, 24-hour care afterwards, which is something that home care can't provide.

"So, I think it's too early to determine if the discharge patterns have been permanently altered. Right now, the conventional wisdom is they'll trend back to normal to pre-COVID," Kessler said.

The company reported that its skilled nursing average monthly occupancy fell from 70% in September to 66% in December and January.

The drop was also noticeable in its private-pay senior living occupancy, which languished at 79%, to 72%, to 71%, respectively, in September, December and January.

Census bottomed out?

Executives noted that while they cannot predict when occupancy will rebound, they are assured that it will recover to pre-pandemic levels.

“We do believe that the industry census is close to or has hit bottom,” Chairman and CEO Wendy Simpson said.

“As the current vaccines, and hopefully a third from Johnson & Johnson, become more widely available and utilized, visitation opens up, communities and facilities continue to aggressively market their services and consumers’ confidence in these settings improve, we should see the current census stabilize and even improve,” she said.

“However, visibility to these events remain low so we can’t predict when that might happen or when the industry will be able to fully recover from the effect of the pandemic,” she added.

McKnight’s
LONG-TERM CARE NEWS

Another COVID-19 Symptom: Dueling Liability Decisions

Written by: Neville M. Bilimoria

2/19/2021

If you thought you had a clear read on how courts would interpret federal COVID-19 liability protections, think again. After a set back last fall, there appears to be some good news for providers after all.

In December 2020, I shared how a federal court in Pennsylvania ruled against a nursing home’s liability protection claim in *Sherod v. Comprehensive Healthcare Management Services, LLC*. In that case, the court decided a nursing home could not use immunity granted through the federal Public Readiness and Emergency Preparedness, or PREP, Act to fight a housekeeper’s COVID-19 wrongful death suit against the facility.

In *Sherod,* the court ruled PREP Act immunity for COVID-19 countermeasures did not apply because the plaintiff alleged a “failure” on the part of a nursing home to take action to protect its staff and residents.

But on Feb. 10, a federal court in the Central District of California ruled in favor of an assisted living facility and granted PREP Act immunity against a plaintiff who claimed the facility took inadequate safety measures to protect against COVID-19.

In *Gilbert Garcia et al v. Welltower OpCo Group LLC, Sunrise Senior Living Management, Inc. et al*, the complaint accuses the defendants of failing to take adequate measures to prevent the spread of COVID-19. The case was filed by the surviving sons of a former Sunrise resident.

In *Garcia*, the court ruled the plaintiff could not criticize the infection control, PPE and other measures taken by the assisted living facility because the facility was deemed a “Covered Person” under the PREP Act and was,

therefore, afforded immunity for undertaking those countermeasures during the pandemic.

The plaintiff argued that PREP Act immunity only applied to emergency vaccine administration and not other policies, procedures and infection control programs associated with COVID-19, all of which could be the basis for a negligence claim. The plaintiff further argued that there are no guidelines from the Department of Health and Human Services that show a countermeasure covered under the PREP Act would include social distancing policies, infection control policies or employee restrictions in preventing the spread of COVID-19.

The court disagreed. Why? Mainly because the court recognized two significant HHS Office of the General Council advisory opinions on the PREP Act from October and January. In these opinions, HHS made it clear that even a nursing home's failure to act as part of a program plan to combat COVID-19, could be part of a reasoned "countermeasure" that would afford a facility complete immunity under the PREP Act.

HHS advisories carry weight

The Court basically sided with HHS' own interpretation, respecting that agency's interpretation of the PREP Act among nursing homes and assisted living facilities. Specifically, the Court and HHS recognized that resources during the pandemic were scarce. If, as part of a facility's COVID-19 plan, a facility rationed resources or took only some countermeasures rather than all to effectively combat COVID-19, PREP Act immunity would protect those facilities against lawsuits.

That finding comes despite the earlier *Sherod* case and other plaintiffs that may argue a failure to act is not a "countermeasure" and is, therefore, outside the purview of the PREP Act's protection:

"Where a facility has been allocated a scarce therapeutic purchased by the federal government and that facility fails to administer that therapeutic to an individual who meets the requirements of the FDA's authorization, approval, or license, and whose physician prescribes that therapeutic, then the facility's refusal to administer that therapeutic could still trigger the PREP Act assuming the non-use of the therapeutic was the result of conscious decision-making. However, the facility may still be liable under the PREP Act, if the plaintiff alleges that the decision to deny him or her the therapeutic was wanton and willful and resulted in death or serious injury…

Program planning inherently involves the allocation of resources and when those resources are scarce, some individuals are going to be denied access to them. Therefore, decision-making that leads to the non-use of covered countermeasures by certain individuals is the grist of program planning, and is expressly covered by PREP Act."

— HHS Advisory Opinion 21-01, pp. 3-4.

What the *Garcia* case means for facilities practically is that all COVID-19 conscious decision-making by facilities should be documented, with real-time rationale as to why certain countermeasures were or were not taken. That will allow a facility to take maximum advantage of PREP Act immunity.

Nursing homes and assisted living facilities should take precautions to justify their COVID-19 policies and procedures, juxtaposed against any lack of resources that may or may not be available at the time. Doing this will help protect facilities by affording them the broad immunity of the PREP Act as interpreted by HHS and the *Garcia* case.

With the seemingly different approaches taken by the *Sherod* case and the *Garcia* case, it is likely that the question of PREP Act immunity among nursing homes and assisted living facilities will be subject to further decisions. For now, facilities should take *Garcia* as a clear victory, and hope other courts will follow its application of the PREP Act in favor of long-term care facilities as they continue to combat COVID-19. Stay tuned.

Despite COVID, Nursing Homes Look to I-SNPs to Turn Value-Based 'Mirage' into Reality

Written by: Alex Spanko

2/16/2021

The average U.S. nursing home has operated in a kind of survival mode for the last year, with long-term goals around new clinical and reimbursement models shoved aside to tackle the immediate and persistent scourge of COVID-19.

That said, some facilities were still able to execute on previously developed strategies to enter the world of Institutional Special Needs Plans (I-SNPs), unique Medicare Advantage plans that cover long-term residents of nursing homes and other communal residential facilities.

As chief development officer at American Health Plans, Hank Watson has had a front-row seat to observe the pandemic's effects on I-SNP rollouts; the Franklin, Tenn.-based company develops the plans through joint-venture partnerships with operators in nine states, while parent firm American Health Partners also owns and operates nursing homes across the Southeast.

Watson joined SNN's "Rethink" podcast to discuss the impact of the pandemic on the I-SNP model, and why both he and nursing home leaders still see concrete clinical and financial benefits to serving as both operator and insurer — with Medicare Advantage forming a rare bridge between the often diametrically opposed worlds of fee-for-service and value-based reimbursements.

Excerpts from the interview, conducted late last month, are published below; for the full episode, check out the full episode on Apple Podcasts, Google Play, or SoundCloud, and be sure to subscribe so you never miss an episode.

How has COVID-19 changed the I-SNP calculation for providers?

As you know better than anyone, COVID was the most impactful event to have occurred to the nursing home industry, and continues to be. There are obvious challenges for provider-owned I-SNPs in that environment — facility access and census, clinical execution. All this is occurring in a relatively new partnership, a joint venture arrangement among providers and American Health Plans.

But I'd say despite those challenges of 2020, and continuing in 2021, with COVID and all the difficult moments, I would say the I-SNP model certainly held. It's certainly been our experience for each of our five 2020 I-SNP plans.

They all have their own story, but overall, the model held. And what I mean by that is not just the CMS I-SNP model, and beyond the financial arrangements and considerations — the joint venture and the operating model that our partners at American Health have put together and put in place.

As a collective group, we were able to manage our hospitalization rates at around 3.5%. We were able to pay shared savings across our book of business at about a 25% clip over top of capitation. I think what really

highlighted the challenges of 2020 was that structure, that day-to-day execution that was required to realize those results.

Obviously, we were executing in the most difficult circumstances. But an I-SNP is really a coordinated dance between the facilities, the operating partner, American Health in this example, but also the care management entity as well.

When you get into an operating environment like 2020, it stress-tests those relationships, and how that partnership is set up: Are the facilities fully committed to executing the model of care? Is the care management entity integrated with the plan in a way that it can be responsive to the changing environments that we're facing? Is the plan operations partner willing and able to be creative and flexible with the realities that a facility may be facing on any given day? And then is the joint venture itself set up to ensure that everyone is thinking long-term, providing proper governance through difficult patches and pulling their own weight?

Two examples. We had one plan at launch just prior to COVID hitting. We had our trying days, for sure, but the organization that we partnered with was well prepared. They had contracted I-SNPs previously in their homes, so they trusted the clinical model, and knew there was a lot of value being left on the table by not being a provider-owned arrangement.

They partnered with us, and they worked openly with our care management entity to expand the program into their homes, and navigate the many challenges that fell on us just two months into launching the plan. And the result was: They were able to get some shared savings results out of it, and we're now looking to continue to grow and expand the membership and double that this year.

Conversely, another plan of ours that was probably most impacted — our collective plan was a lot of rollout of facilities, for a number of reasons, was to occur in Q2. So obviously COVID delayed those rollouts, as everybody was digesting the new realities around them, and that pushed back our plans for scale by a good six to nine months. But the partnership remained open, communicative. Everyone took it a day at a time, and we're now executing on that backlog of growth, looking to bring in additional partners and execute on geographic expansion.

The model is there. The model works. It's founded in a much more improved model of care. But the partnership does need to be patient, collaborative, transparent. Those are the nuances that are really important. We spend a lot of time talking about facility economics, and the blocking and tackling, but it is a partnership — and that part of it matters as much.

Let's say I'm an operator who's still curious about I-SNPs after all we just saw over the last year — what are the potential advantages to jumping in now, even with all the uncertainty surrounding the sector?

The benefit of the I-SNP is: You're ultimately getting to the top of the food chain and controlling the Medicare dollar. So while it could be a long-term strategy in terms of positioning your nursing home organization higher up the food chain, and in terms of engagement in the health system and your local market, on day one, you're getting premium payment from CMS monthly. You're getting capitation to your facilities monthly, so the immediate cash flow effect is positive.

Additionally, you are getting access to that model of care immediately. There may be long-term strategic implications, but you're not taking a step back financially to go forward in this model, which is appealing, and there is a cash flow component to this that is positive with capitation.

What we're seeing in terms of folks looking at participation, and new plan activity — despite all the challenges of 2020 and census pressures and the like, the provider-owned I-SNP membership did grow entering 2021. I think

a lot of that new plan activity was momentum through pre-COVID discussions and efforts, given the cycle that CMS requires.

But one of our new partners in Texas — a new market we're in — a real sharp CEO, at the moment the height of uncertainty in May and June, she pointed out that she viewed COVID as evidence of the need for the I-SNP model of care. She was doing everything she could clinically to manage these residents in their home, which, of course, is the nursing home.

That said, as we're looking into the future here in 2022, I think what you'll see [driving] a lot of activity is depth in the market. Take American Health Plans, for example. We're now in nine states, so an emphasis will be creating depth in those states through filling out opportunities with existing partners. Maybe your operations are in 40 counties, but you initially go live in 20, so you have the opportunity to fill out that opportunity by expanding geographically, and then also engaging new interested participants in those markets.

That's a tremendous advantage for a group that maybe is operating, in this example, in Texas — rather than having to make a decision a year and half out to begin to develop and operationalize through all the steps required to launch an I-SNP, there's one now operating in their market. And the opportunity to engage and plug in, effectively day one, it cuts down on that lag time to engage with the I-SNP and realize that economic and clinical opportunity.

I think the other component that we'll be focusing on, certainly in those markets, is expansion of our product offerings: You can also expand into an institutional equivalent setting, ALFs and the community and the like.

Then for the groups that are emerging, with the vaccinations and a little relief — maybe just the need to look forward after 10 months of battling day to day. Those conversations are focused on 2023 new plan opportunities, and so there's some time to get up to speed and create that strategic plan for those organizations around a new plan.

Logistically, how has the I-SNP rollout changed? Historically it's been very hands-on, between implementing new care strategies and marketing the plans to residents and their families.

When we talk about I-SNPs with partners and potential partners, the nursing home owners, what they're seeking from the I-SNP is a vastly improved model of care, the capitated cash flow, and the opportunity for shared savings. To access those three things, the provider-owned I-SNP has to deal with really two factors at a high level. We call it capital and execution.

What you're asking about is the execution piece. On the capital side … yes, you'll need your $1.5 million, $2.5 million in statutory capital; you'll need a couple more million to get stuff stood up and get to scale. But the syndication allows for a lot of flexibility from the nursing home side. We've got partners in for less than $500,000 that are still realizing those three goals of the I-SNP — the model of care, capitated cash flow, and shared savings.

On the execution, that really boils down to enrollment and hospitalization, if you had to summarize it. If you execute on those two points, the rest will follow. But there's a lot that goes into those factors, and to your point around launching the program and marketing it — that's where we believe a very integrated model between sales, clinical field operations, and back-office health plan operations is really beneficial.

I think as providers are continuing to look at this model, [the questions have evolved from]: What is an I-SNP? To then: What's the map on capitation, relative to fee-for-service? The next step is: What's the operating model here?

So 2020, to your point, put a lot of stresses on that. But we were able to navigate the move to virtual enrollment, navigate the move to virtual facility education leading up to launch — and really ongoing facility education, because you always have a new administrator, or you're constantly enrolling new admissions and educating the facility on that process. A medical director inevitably will have questions about the program that you'll be addressing and wanting to collaborate with.

All those things, of course, move to a virtual environment. But I think a program that had a comprehensive operational approach allowed for us to pivot and make that work, so that the end result — the last step of the enrollment process, talking to the resident or the POA — didn't change in terms of 80% uptake when you get to that point.

Of course, the challenge was getting to that point through facility education and virtual engagement of those residents and the POAs. But we're able to navigate that through a comprehensive and clinical effort between operations, the care management team, and the sales team.

Let's drill down on the clinical piece of this, because I feel like most of the attention centers on controlling the Medicare dollar. What are some of the challenges and benefits of establishing the clinical component of the I-SNP model?

The clinical team has to be on the same page. This whole provider-owned model contemplates the nursing home being fully invested and having skin in the game, the operating partner being fully invested in having skin in the game. But what often gets left out is the care management piece.

If that is fragmented and cobbled together, for lack of a better term, through whatever's in place already — or "let's go find somebody in that local market that can can fill this void" — that model of care execution is where the rubber meets the road. All the conversations around capital, and shared savings, and enrollment — enrollment is driven by the model of care. If that's not happening, you'll feel that in all those different places.

For us, the only way to ensure that that is all aligned operationally, and with the facilities, is for that to be affiliated with the joint venture between the nursing homes and the I-SNP partner, American Health Plans in this example. We have an entity called TruHealth. They do a wonderful job; their entire focus is to execute the model of care on behalf of this I-SNP joint venture.

That's what they do every day: They work with the field operations team every day, they work with the facility folks every day to that end — so they're not walking room to room, trying to put on a fee-for-service hat, taking that off, [putting on a] care management hat and trying to navigate different models. The whole idea here is to strip away the challenges of a fee-for-service environment, and the need for a nurse practitioner, RN model that requires 15, 16, 17 visits a day to a model that is intensely focused on the needs of the resident-member in the model of care.

If they need to sit with that member for two hours, that's what they'll do, and that's what leads to the proactive care — and ultimately, the prevention of hospitalizations, ownership of calls on weekends, and doing it in a way that's collaborative with the facility, collaborative with the facility's medical director and the existing clinical team in place.

That's the execution. That's the magic of this model, and that's where you have to have everybody fully invested. That's why we put so much emphasis on that component of this, because nothing else works if you're not executing at the bedside.

This interview has been condensed and edited for clarity.

Advocates Push Back on Geography as Driver of Nursing Home Outbreaks — and Detail Drastic Measures for Keeping COVID at Bay

Written by: Maggie Flynn

2/18/2021

COVID-19 outbreaks in skilled nursing facilities are affected by more than geography, and nursing home operators have tools and actions they can take to mitigate the spread of the virus in their facilities, the Center for Medicare Advocacy (CMA) argued in a report released on Thursday.

“Since the start of the pandemic, one of the most widely shared explanations for the devastation that we’ve seen in our nursing homes has been that where a facility is located will define how much they’re able to protect residents from COVID,” Cinnamon St. John, a health and aging policy fellow at CMA, who authored the report, said in remarks on a webinar marking its release on Thursday. “But when you look at the data, and examine the world of research around this topic, and speak to those who are out there, battling this disease every day, which my report has done, it becomes clear that this simple explanation just does not stand on its own.”

CMA is a non-profit law organization that advocates on behalf of Medicare beneficiaries.

The CMA report drew from Centers for Medicare & Medicaid Services (CMS) COVID-19 data set through December 27, 2020, as well as data from the CMS Care Compare Database. It also used interviews with nursing home administrators in Los Angeles County, Calif.; Maricopa County, Ariz.; and Hartford County, Conn.

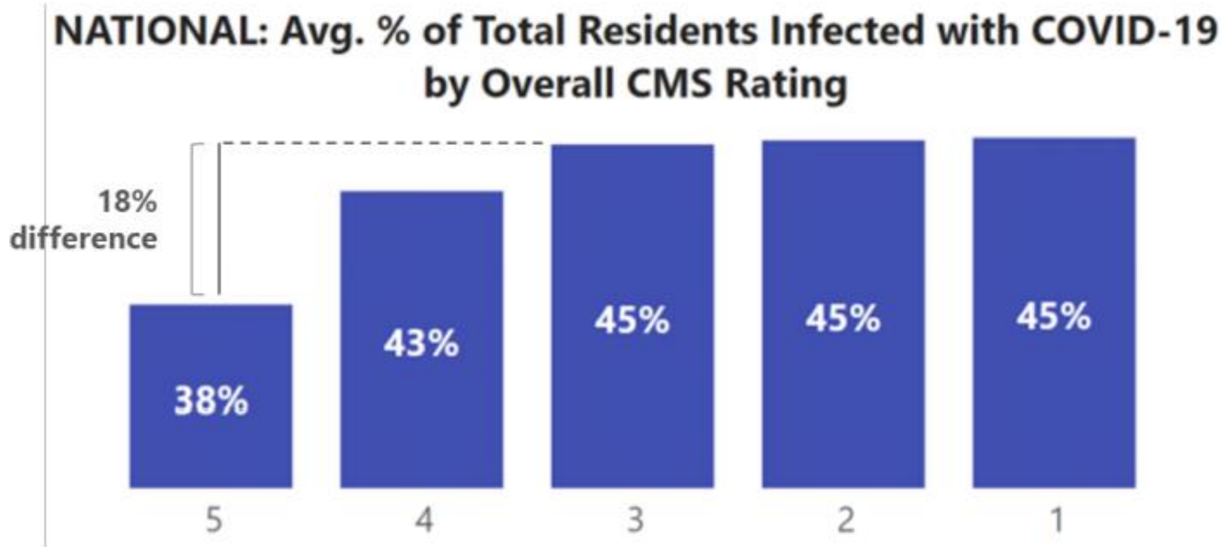
The group in particular called out an August article published in the Journal of the American Geriatrics Society by Rebecca Gorges and R. Tamara Konetzka, which concluded that community spread was a top predictor of outbreaks, despite staff playing a key role in how those outbreaks played out.

“This argument, however, is certainly neither ironclad nor the entire story,” the CMA report said.

In the report, St. John examined a variety of factors that played a part in the severity and effect of COVID-19 outbreaks in nursing homes, including CMS overall star ratings, ownership, personal protective equipment (PPE) and the availability of COVID-19 testing for residents and staff. It also provided a range of actions and policy recommendations centered around leadership and staffing, physical plant standards, and protocols for infection prevention and control and following public health guidance.

The report found SNFs with a five-star rating from CMS were 18% more effective at preventing COVID-19 infections — logging total resident infections that were 7 percentage points lower than three-, two-, and one-star SNFs. Specifically, five-star facilities reported an average infection rate of 38% of residents, compared with 43% on average for four-star facilities and 45% for three-, two-, and one-star facilities.

(Article continued on next page)



Source: Center for Medicare Advocacy

In terms of quality, nursing homes in the top 10 percentiles by COVID-19 cases per 1,000 residents had an average CMS quality rating of 3.8. Those in the bottom ten percentiles had an average quality rating of 3.5.

Staffing ratings showed a particularly notable disparity, with a 9.7% difference between those in the top ten percentiles by COVID-19 cases per 1,000 residents and those in the bottom ten percentiles. Facilities that performed the best by this metric had an average CMS staffing star rating of 3.4; those that performed the worst had an average staffing star rating of 3.1.

There was also a wide gulf between best- and worst-performing facilities in terms of testing; just 0.5% of the top performing facilities reported a shortage in staff testing capacity, while 1.4% of the bottom performing facilities did the same. For nursing staff shortages, there was a similarly notable gap; 18.4% of top-performing facilities by COVID-19 cases per 1,000 residents reported a shortage of nursing staff, while 21% of the worst-performing facilities reported this shortage.

There was one interesting, counterintuitive finding: Of the top-performing facilities by COVID-19 cases per 1,000 residents, 21.2% reported a shortage of nurse aides, while just 20.4% of those worst-performing facilities reported this shortage.

“Though the level of infection found in the surrounding community does undoubtedly create additional challenges for nursing homes battling to keep COVID-19 at bay, as this data makes clear, a facility’s location does not equate to a facility’s fate,” the report argued.

The August 2020 study by Rebecca Gorges and R. Tamara Konetzka, which studied data from 13,167 nursing homes that reported COVID-19 data as of June 14, 2020, had several conclusions that were similar; it found that higher nurse-aide (NA) hours and total nursing hours were associated with a lower probability of experiencing an outbreak, and were correlated with fewer deaths.

That study found that higher registered nurse hours were associated with a higher probability of experiencing any cases, which could possibly be related to the increase of traffic in and out of a facility, the authors noted in their discussion. However, the UChicago study found that the factor with the greatest effect on outbreaks was where the virus was circulating in a community.

"The prevalence of COVID-19 in the community remains the strongest predictor of COVID-19 cases and deaths in nursing homes, but higher NA hours and total nursing hours may help contain the number of cases and deaths," Gorges and Konetzka concluded at the time.

Keeping COVID-19 out

Rev. Dr. Derrick DeWitt Sr., the director and chief financial officer of the Maryland Baptist Aged Home in Baltimore, spoke during the webinar about how he kept COVID-19 out of his facility.

The Maryland Baptist Aged Home has 30 residents and 42 full- and part-time employees who have been free from COVID-19 infection, and DeWitt has been praised widely in the wake of the pandemic for that accomplishment.

His success involved acting early. But he also noted that the operator was "excessive and extreme in our measures."

"Even before the pandemic, I took a lot of criticism by having a full-time infection control and quality assurance nurse in such a small facility," he said. "But we knew that infection was going to be the thing that either made us or closed us. If we kept infection out, we would have success in remaining open as we have for 100 years."

DeWitt had to take a pay cut to hire the infection control nurse, but did so based on the premise that infection control could not be a "side duty" in a health care facility. When the pandemic struck, infection control took center stage, and according to DeWitt, the work of the infection control nurse formed the basis of how Maryland Baptist responded.

That response necessitated going "above and beyond the guidelines."

"Everything that she had in the book, I said: Let's multiply this times 10 and do it," DeWitt said.

That included stockpiling PPE immediately before shortages emerged, and closing the facility to visitors on February 28, 2020.

It also meant making drastic changes to how employees approached work.

"We told our employees: Don't take public transportation, wear masks at home, and limit your exposure to your family," DeWitt said. "It's very extreme measures, right? We're invasive. And our questionnaire doesn't just ask: Have you had contact with people? We want to know: When you left the facility, what did you do, and who did you do it with? We were very intrusive. We're checking social media. I've suspended workers for 14 days with no pay because they went to a party during the pandemic. These are some extreme measures."

To offset the challenges of not taking public transit, Maryland Baptist provided supplemental transportation to prevent employees having to take the bus and the train. It also hired more activities personnel to try to combat the toll of isolation on residents.

But it also faced some challenges implementing these measures. DeWitt emphasized strongly the need to focus on care and not funds — while noting those funds for care need to be sufficient.

"It's got to be about the care and less about the money," he said. "The other way to look at it is that the money that we get from Medicare, Medicaid, is not enough to provide the quality of care that's needed. A lot of the measures that we've done, it was at great financial sacrifice."

Maryland Baptist Home has a registered nurse on every shift, for instance, which helped maintain quality assurance related to care. That coverage on top of the additional activities personnel poses a fiscal challenge.

“A lot of problems that I see with Medicare, Medicaid, those types of payment models especially for non-profits — the margins are so tight that it’s hard to focus and to put in a lot of these measures that will lead to the safety of our residents,” DeWitt said.

He also pointed out the disproportionate toll of COVID-19 on nursing homes where people of color live, relative to other nursing homes, as an example of the need to account for the fact that long-term care facilities differ by community. That study, also by Gorges and Konetzka, found that several factors played a role, with the larger size and poorer quality of nursing homes in those areas — combined with overall higher community case counts in those areas — a particular issue.

“I want to be careful in saying that it is important to note that nursing homes could have done everything right and still have been affected negatively by this pandemic,” he said. “But I think that we have to begin to look a the models of larger facilities … it’s hard to control infection, once it’s entered your facility, if you have a large facility, a large workforce. We have to begin to look at smaller, community, neighborhood-type facilities that are designed based on the differences in those communities, centered around long-term care.”