The Sustainability of Person-Centered Care During a Pandemic: How COVID-19 Impacted Culture Change Efforts in Nursing Homes

This report describes results from a survey of nursing home administrators and other staff in communities affiliated with The Green House Project, Pioneer Network, the Eden Alternative, and the Live Oak Project —organizations dedicated to overhauling the institutional nursing home culture that far too often has prioritized operator convenience, efficiency, and profit over resident quality of life. It was conducted by Altarum, a nonprofit organization focused on advancing the health of individuals with fewer financial resources and populations disenfranchised by the health care system, during January and February 2022. It describes areas of progress and backslide in person-centered practices during the Covid-19 pandemic, along with workforce developments, key reflections, and future considerations.

Abstract

It is widely appreciated that COVID-19 has had a catastrophic impact on residents living in and receiving services in many U.S. nursing homes. What is less well understood is whether nursing homes identifying as "Culture Change" homes have continued person-centered practices and protocols during an era when infection prevention and control have necessarily become much more dominant. We set out to examine this in a convenience sample survey conducted in early 2022 that netted 62 responses from nursing home administrators and managers in 30 states. Our results suggest that while severe, the impact of the pandemic has fortified the drive of staff in culture change homes to continue to adapt—not to revert to traditional, institutional-style care practices. Notably, nearly three-quarters (71%) of culture change measures related to resident quality of life were either maintained or expanded in at least 60% of surveyed sites.

KEY FINDINGS

60% *of respondents maintained most culture change measures*

77% *support residents' interests*

87% *had no restriction on visitors in March 2022*

81% *made physical changes to facilitate COVID-safe gatherings*

61% *expanded video calls and e-mails to connect residents and loved ones*

ALTARUM
SOLUTIONS TO ADVANCE HEALTH

Pioneer Network

Live Oak Project

the green house project Revolutionizing care to empower lives.

THE eden ALTERNATIVE

Other key findings from the group of 62 nursing homes in 30 states include:

- 77% maintained or expanded efforts to learn and support residents' interests
- 87% had no restrictions on visitation as of March 2022, and 81% reconfigured or updated indoor space to better facilitate COVID-safe gatherings
- 61% expanded support for virtual communication, such as assistance with video calls and e-mail

Nursing Home leaders did report scaling back or eliminating some aspects of resident choice, e.g., having community members participating in on-site activities, arranging for residents to go to events off campus, and providing more than one place to dine. However, these actions paralleled what was happening in the wider community. Despite these limitations, sites continued to work to find ways to create a meaningful life for residents, even as certain culture change practices that require additional staff time were decreased or temporarily discontinued, partly due to workforce shortages. As the pandemic recedes, culture change homes are clear about "lessons learned" and about new opportunities for a range of improvements. One area we identify as needing investment is the formation of more family councils, since 63% of sites reported that they did not have an active and engaged family council.

Background

During the pandemic, a myriad of medical and social adaptations have been required of nursing homes. Limitations on communal dining and internal and external group activities; restriction of building entry to non-medical personnel; discouragement of outside trips for residents for anything other than medical reasons; creation of dedicated space for cohorting and managing care for those residents ill with COVID-19; and social distancing, mask wearing, full PPE gear, screening, and more have all combined to shift care patterns and daily life for residents during the two years since the pandemic reached the U.S. In some homes, stringent infection control practices continue.

> *"The complete "lock down" was a huge detriment to both physical and mental health of our elders. We won't ever go back to asking elders to remain in their rooms 24/7 when there is an outbreak."*

For more than 30 years, innovative culture change initiatives that aim to make nursing homes engaging places to live rather than unpleasant institutions have been developed in a mostly *ad hoc* fashion and have demonstrated benefits for both residents and staff. Many, though not all, of the progressive person-centered practices and protocols that have been developed and tried have been discussed and detailed in journals, newspapers, magazines, trade publications, seminars, and conferences. Most importantly, individual nursing homes have served as laboratories of quality reform. In general, nursing homes that have pursued culture change have done so because they are strongly motivated to improve resident choice and experience and because they recognize the necessity of providing a high quality of life (QOL) to residents. Over time, what has emerged is a gradual coalescing and greater understanding of how person-centered care techniques work to improve QOL, and how these protocols can also bolster the role of direct care aides.

While the traditional nursing home model prioritizes efficiency for the provider over personal

preferences of residents—e.g., establishing a time when all residents must be awakened for breakfast, nursing homes that are influenced by culture change training, coaching, mentoring, and ongoing quality improvement focus instead on what individual residents want and need to feel valued. In the context of daily routines, this means that if a resident isn't an early riser by choice, then staff members make it possible for the resident to sleep longer and have breakfast at a later time. In practice, therefore, culture change requires those providing care and the systems in which they work to be flexible and adaptable.

The patterns and practices of culture change have been severely tested during the COVID-19 pandemic. The rapid spread of the novel coronavirus has taken the lives of over 210,000 residents and nursing home staff as of January 2022. As of early April 2022, nursing home resident deaths have been estimated to comprise 23% of all COVID deaths while this demographic comprises under 1% of the total U.S. population. The high mortality rate from COVID-19 contributed to a decision in March 2020, issued by the Centers for Medicare and Medicaid Services (CMS), that ordered nursing home administrators to close their sites to most outside visitors, including family members, under all but narrow circumstances. Thousands of residents were then confined to their rooms on a round-the-clock basis. For six months, residents suffered from a lack of most human interaction except with staff, and many did not even see fellow residents.

The nationwide scale and toll of prolonged social isolation and loneliness that occurred during this "lockdown" from March until mid-September 2020 was unprecedented and seems unlikely to be repeated. It is now better understood that well-intentioned efforts by many nursing homes to keep residents safe wound up causing additional inadvertent harm in the form of despondency, failure to thrive, and withdrawal. Many resident advocates, including long-term care ombudsmen, are continuing to focus on mitigation of social isolation and loneliness among residents and to soften the impact of a resurgence of the "medical model" of care that is organized around tasks that are mainly concerned with a resident's physical health and less with their relationships, ability to exercise autonomy of personal preferences, and the impact of the environment on quality of life. The authors wanted to explore how nursing homes that had already adopted culture change practices prior to the pandemic fared. Were they able to maintain person-centered practices?

Method

To investigate this, Altarum surveyed 62 nursing homes that participate in the networks of The Eden Alternative, the Green House Project, Pioneer Network, and the Live Oak Project across 30 states. Sites were asked to determine if specific culture change practices – such as residents choosing when they want to wake up – had been expanded, maintained, scaled back, or eliminated during the pandemic. "Not used" was also a response option. Additionally, administrators were surveyed on staffing practices – such as whether the home used National Guard members to assist or whether they used temporary agency staffing. They were also asked whether their site made use of CMS' Training and Certification Nurse Aide waiver flexibility, which allowed homes to hire direct care aides with only eight hours of initial training as compared to pre-pandemic standards of 75 hours of training. Importantly, questions about staff pay and benefits were included along with vaccination levels and occupancy. In terms of respondents, 68% of those surveyed identified as nursing home administrators, 2% identified as directors of nursing, and 31% did not specify their role.

Areas of Progress

Despite the challenges of the pandemic, well over half of responding sites said they did not lose ground on many of the person-centered practices that define culture change. This is reflected in the fact that for 17 of 24 resident quality of life-related questions over 60% of sites reported that they had either maintained or expanded their culture change efforts.

Exemplary metrics include the fact that as of March 2022, 87% of sites reported they were not restricting access to outside visitors, and 81% of sites had reconfigured or updated their indoor space to accommodate socially distanced activities. Many sites simply rearranged tables and other furniture in existing spaces – often dining rooms – to accommodate safe gatherings and activities. Some sites created hallway programs to ensure socially distanced engagement.

Many respondents developed new outdoor programmed activities. Some of these efforts involved installing large tents or using covered parking areas for outdoor events and gatherings. Several sites created "greenhouse" or "chatter box" structures for outdoor conversations. Others used heaters on patios. One home installed "safe hug" windows for visitors.

> *"We will be better prepared for a future pandemic or other healthcare emergencies."*

Only eight sites reported visitor restrictions in the six weeks of the survey response window. Those homes that still had restrictions in place mentioned a variety of measures, such as reduced visiting hours. However, only a small minority (three) of surveyed sites reported imposing restrictions based on vaccination status and/or lack of recent negative COVID test results. At one of these sites, visitors were limited to family members who were vaccinated; a second required a negative COVID test. The third site would not allow visitors five years of age or younger (a cohort that had not had access to vaccination) and limited visitors to two people per resident per visit to try to ensure proper social distancing.

Resident choice about when to go to bed and when to wake up was also maintained or expanded within 92% of sites, while residents choosing when to bathe was maintained or expanded at 74% of sites. Among the 24 questions related to quality of life, 21 were answerable by "not used, expanded, maintained, scaled back, or eliminated," and three were "yes/no" questions. Overall, responses showed that most sites have maintained, but have not expanded, their culture change practices during the pandemic. While all 21 questions had at least one site reporting expansion efforts, for nine questions, 10% or more of sites reported expansion. Encouragingly, the culture change expansion effort mentioned most frequently was enabling residents to connect with family and friends, including assistance with setting up video calls and email communications. Sixty-one percent of all surveyed sites expanded efforts in this area during the pandemic. Over three-quarters of respondents (77%) either maintained or expanded efforts aimed at learning about residents' interests and helping them continue these – a linchpin practice in culture change organizations.

Thirty-one sites supplied additional comments, many describing plans for quality improvement practices in 2022 that will encourage social engagement between residents and among residents and staff. Gardening, for example, was mentioned three times as an example of a planned activity, and two sites said they would be expanding the use of technology (e.g., tablets) to help residents communicate with loved ones. Another planned to make more use of the resident council in creating activities. One site said more outside trips to the community would be arranged once the community

positivity rate was low enough, and one site had converted an electric wheelchair into an ice cream truck!

In a further analysis of responses to this question, six sites mentioned pursuing Eden Alternative training, and one of these sites also mentioned Teepa Snow's dementia curriculum. One administrator wrote about working hard to return to a home environment mindset – something that the site felt it had lost in the task-oriented nature of pandemic procedures.

Areas of Falling Back

Many of the less positive trends centered around aspects of care and quality of life that would have been the most challenging to adapt to social distancing rules, such as involvement of community members in on-site activities. Fifty-three percent of responding sites reported that they cut back on community group engagement (i.e., having organizations come into the nursing home), and 11% of responding sites eliminated this practice. Also, 40% scaled back and 18% ended intergenerational programming. Most dramatically scaled back were opportunities for residents to attend activities in the wider community, with 57% of sites scaling back and 23% of sites eliminating efforts related to this. It should be noted that engaging with the broader public was something that many individuals *not* living in long-term care settings minimized or avoided in 2020 and part of 2021. By mid-2021, many parts of the country began to allow larger group gatherings. Yet the rise of COVID variants has created uncertainties that persist and which make bringing community gatherings into a nursing home rather daunting.

> *We must be able to pivot fast, we can't do this alone, and we must advocate with government officials to try to help everyone understand the impact of decisions.*

Other areas that experienced larger scaling back or elimination of some person-centered care protocols were those that require significant staff time, such as engaging residents in determining menu selections for communal meals. Thirty-one percent of culture change sites reported scaling this practice back. Similarly, engaging residents in shaping activities was reduced by 40% of culture change homes. Given that staffing was already in short supply in many nursing homes across the country prior to the pandemic, culture change homes shifted more of their attention to meeting residents' physical needs (e.g., eating and bathing), as well as sharpening their focus on infection prevention, infection control, and caring for residents who contracted the virus.

During the pandemic, having dining options in multiple locations became more difficult to arrange, with 58% of culture change homes reporting that they decreased flexible dining times and locations and 11% eliminating this option. And while opportunities for residents to have spontaneous and meaningful enjoyment of simple daily pleasures were scaled back in 36% of sites, no sites eliminated these practices, suggesting that culture change homes remained committed to trying to deliver person-centered care even during the worst period of the pandemic, while also coping with staffing shortages and increased resident morbidity and mortality.

Interestingly, 50% of sites did not reconfigure or update external space for outdoor activities to allow for proper social distancing. This may have been due to physical constraints in available outdoor space at some sites and the limited ability to bring people onto the grounds to work to improve the

outdoor spaces. Alternatively, some sites may have already had outdoor areas that offer sufficient room for social distancing. These details were not clear from the survey.

Person-centered education for staff as part of the onboarding process and as part of ongoing training was scaled back in 29% of homes and eliminated in 5% of sites. Yet only 18% of sites reported scaling back on designating certain staffers as internal "culture change champions," and only 7% eliminated champions. Part of this may have been due to staff leaving or changing employment during the pandemic.

Culture change homes do have an opportunity for potential improvement in forming family councils, which could serve as a bridge for connecting residents to the wider community. Sixty-three percent of sites surveyed reported they did not have an active and engaged family council. Conversely, only 10% had an active and engaged family council pre-pandemic and maintained or expanded it. This may be partly due to the "lockdown" effect – the six-month period during which family members and visitors were largely prohibited from entering nursing homes.

In an innovative and forward-looking approach championed by M. Wasserman, T. King and others in a white paper that was presented to CMS earlier this year, "Advancing Equity in Nursing Homes: Resident, Family, Community Advisory Council (RFCAC) Pilot Program Proposal," the authors observe that "accountability for quality needs to be a key element in any discussion of how to bring about quality improvement. CMS, by regulation §483.70(d)(1) requires each facility to have a Governing Body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility.... the Governing Body is a key element by which to bring accountability for the quality of care in a nursing home...[and that] enhancing the existing role of resident councils to incorporate community members can bring about this accountability."[1]

Specifically, Wasserman et al observe that "developing data-driven satisfaction metrics that reflect the concerns of families and community members" is a critical component for bringing the support and voice of the community to assist resident and families," and that "2 to 5 local community residents" could be selected to stand up and pilot Resident, Family Community Advisory Councils (RCACs) that would serve as the objective ears and eyes of what is transpiring in nursing homes."

With regard to census, the pandemic contributed to a decrease in occupancy at 61% of sites. Only 5% of sites increased occupancy during the pandemic. In February 2020, the national occupancy rate was 85%.[2] By the end of 2020, occupancy had fallen to below 72%.[3] Although it has begun to increase, occupancy nationally was still hovering below 77% as of the end of February 2022[4] – still well below pre-pandemic levels. Further inquiries would be needed to find out whether occupancy in culture change sites dropped by about the same level, or less than, traditional nursing homes. Throughout the nursing homes sector, occupancy rates plunged to as low as 71% in December 2020, rising to 81% a year later.

In response to an open question about infection control practices, survey participants were forthright about the value and greater infection prevention afforded by private rooms and bathrooms. Many of the sites reported already having private rooms prior to the pandemic. One home noted that it had moved to mostly private rooms due to lower census, and another, while not providing a reason, stated that it had transitioned to all private rooms during the pandemic and would not be reverting to double-occupancy arrangements.

Nevertheless, not all culture change sites reported having private rooms, with several stating that while they would like to be able to provide private rooms and bathrooms, they cannot due to financial constraints. Some observed that their physical plant's footprint would make renovations costly, and/or that extensions would need to be added to accommodate private rooms. The capital needed to renovate a building is a barrier for some sites, and others expressed concern about a loss in revenue if census were to decrease by half. A few sites reported having both private and double-occupancy rooms. One participant said there is a need in their community for more housing for elders and opined that converting to private rooms could mean fewer individuals would be able to locate good services and accessible housing. Another questioned whether Medicaid would be willing to reimburse for private rooms.

In open-ended questions, many respondents called for more infection control training for staff. They also acknowledged the difficulties presented by staffing shortages, and some said they believed that agency staff present challenges for improving infection control (likely because agency staff are temporary and may work at multiple sites, which may have varying protocols). Several administrators expressed a desire to bring back intergenerational programming and to use volunteers for this purpose, along with generally enhancing visitation options. One home suggested that educating families about how to think about the relative risks of community outings would be helpful, i.e., choosing a time of day and a day of the week to minimize the chances that elders would encounter crowded settings and events.

Overall, faced with COVID-caused challenges, culture change homes worked diligently to adapt, to be resilient, and to maintain—and even in a few cases to expand—person-centered care efforts. Most of these sites provided proactive assistance to help residents communicate regularly with loved ones remotely, and reconfigured and/or updated indoor space so that as many activities as possible could continue with social distancing. These efforts can be seen as innovations to promote quality of life, while also adjusting to the constraints imposed by the pandemic. This is evident in many of the open-ended responses. For example, one administrator stated, "we have created a clear understanding and expectation of medical staff roles and responsibilities, [and] maintain strong and active networks with our colleagues. Their help is invaluable." Another noted that "we need to be crisis-ready all the time. We need to empower our staff and make them feel like they are part of a team. Everyone matters, and we can't do this without every person. We will take steps to educate staff who don't 'get it,' or discipline them out of the organization."

Workforce Developments

During the pandemic, a full three-quarters of sites either expanded or maintained consistent assignment of staff to residents. Seventy-seven percent said they offered direct care aides regular opportunities for career advancement (described further below). With regard to compensation, most sites (89%) provided hazard pay at some point during the pandemic, and 69% reported providing extra paid sick leave. At the time of the survey, 27% of homes said they were currently providing hazard pay, and 29% were offering extra paid sick leave.

Notwithstanding these efforts, the sites surveyed have not remained untouched by workforce shortages. Among respondents, 29% reported difficulty retaining direct care staff at some point during the pandemic, but not currently, while 58% reported current challenges in retaining direct

care staff. Fewer sites seemed affected by administrative staff retention issues. Twenty-six percent reported having challenges retaining administrative staff at some point during the pandemic but not currently, and only 15% reported current difficulty retaining administrative staff.

Diving further into specific ways that culture change homes approached managing workforce shortages, 79% said they never had to use emergency and public health response workers, such as the National Guard. Only 3% were using such teams when surveyed for this study. Nearly one-quarter (24%) of surveyed sites said they did not make greater use of temporary staff during the pandemic, but 71% said they had, or were currently doing so. Three sites mentioned recruiting internationally, and one has created a resident assistant position that does not require a CNA credential.

The use of temporary CMS Training and Certification Nurse Aide Waiver flexibility (wherein Temporary Nurse Aides were allowed to be employed with only 8 hours of online training) was more common, with 31% of sites reporting that they were using this flexibility at the time of the survey, and 24% reporting they had used it at some point but not currently. However, 39% of sites said they never used this flexibility, which CMS announced in April that it would phase out over a 60-day period (with some limited exceptions).

> *We learned the importance of addressing mental health needs of staff, and figuring out how to decrease burnout/PTSD. How do we bring joy to the everyday?*

Career Advancement

Twenty-nine sites provided information about opportunities for direct care staff career advancement. Among these, 15 said they have career ladders for direct care staff and/or are actively recruiting and promoting aides from within the organization. Nineteen sites reported offering tuition reimbursement/assistance or scholarships for certain employees; however, several sites also mentioned that these opportunities were either rarely taken advantage of or were difficult to arrange due to a lack of reliable and affordable programs in the area. Nine sites said they supported CNA training opportunities with six sites offering in-house CNA training. Several mentioned offering either CNA apprenticeship programs or mentorship opportunities, and one highlighted starting a CNA medication aide class.

One innovative home said they have developed a partnership with a community college CNA training program, and another is establishing a nurse training program that sends students to the nursing home. Cross-training to maximize flexible use of staff is being used at eight sites, with one emphasizing that all leadership members have either been trained as CNAs or as nurses and can, therefore, be called upon to assist with direct care as needed.

Addressing Staffing Challenges with Financial Solutions

When asked to describe innovative staffing solutions, the top responses were about financial compensation. The most common offering reported by homes was bonuses, with 14 sites reporting these in varying forms, ranging from retention and sign-on bonuses, to referral, “perfect attendance” and “years-of-service” bonuses. Raising wages, updating pay scales, and conducting wage analyses were the next most common solutions mentioned, with nine sites noting that they have implemented at least one of these. Other financial incentives included providing weekend pay differentials (two sites), pandemic “appreciation” pay (one site), and a pay increase if the staff vacancy factor was

greater than 25% (one site). Another site said they had instituted a "buy back paid time off" policy.

Flexibility in shift length and schedule was another staff retention/recruitment strategy. For example, two sites were backing self-scheduling efforts and flexible shifts for staff; two offered split shifts; two mentioned offering shifts of different lengths; and one said they were hiring more part-time staff. All of these mitigating techniques can help to reconcile differences in personal schedules, while also providing an opportunity for staff to work as their personal life allows. For example, being able to work most of an additional shift instead of picking up an entire second shift—to accommodate a staffer's need to attend to their children, for example—is a practical adaptation that can be considered for wider use. Moreover, respondents observed that picking up a half shift after a scheduled full shift may seem more doable than a double shift.

Fewer sites were prepared to offer additional permanent benefits. One site mentioned offering 15 hours of additional PTO for a successful referral. Another offered flexible PTO, and another offered several paid holidays. One site offered reimbursement for tuition, for day care, and for mileage.

"Top Three Lessons"

In open-ended responses focusing on the "top three lessons learned" during the pandemic, a common response focused on the need for consistent infection control and better preparedness. Equally prominent were responses about the importance of human connections for residents—and the negative impacts of social isolation and loneliness—along with a desire to do more to address mental health needs of staff and to support employee wellness.

> *Educate staff, residents and families to ensure cooperation. Take care of your team. Don't allow staff to work sick.*

Other frequently mentioned themes included a recognition that excellent communication is essential—with both staff and families, and concerns about how nursing homes were asked to respond and immediately adapt to rapidly changing federal and state rules and requirements. In addition, the importance of being able to access more education and training received many comments, and there were multiple observations about the need to build and celebrate resilience among staff and residents, and the essential role that coordinated teamwork plays in addressing serious challenges.

Immediately below are key reflections captured from culture change home administrators, DONs and other leadership staff:

- All staff need to be cross-trained.
- Everyone is scared of the unknown.
- This [Covid-19] is not going away.
- Education is key.
- Sanitation is golden.
- Keep residents engaged.
- We are stronger than we think we are.
- Follow IC [infection control].
- Value your team.
- Always be prepared to be self-sufficient as there is not much outside help during disaster time.

Next Steps in Driving Toward Further Improvement

While COVID-19 has underscored the urgency of a consistent focus on infection prevention and infection control in nursing homes, these practices by themselves do not address the "whole person" needs of residents. The importance of helping residents cultivate relationships and to feel personally valued is an equally essential part of providing quality care—and a necessity for residents to thrive.

In this context, it is heartening that culture change homes responding to this survey found ways to maintain and expand meaningful engagement, resident choice, and social interaction during the pandemic. These sites were also able to maintain culture change efforts in tandem with increased infection control practices and additional regulatory reporting requirements. For example, as one administrator explained, "we have developed creative ways to encourage residents to wear masks when outside their rooms; we have increased cleaning of high-touch areas; we have a plan in place for residents in the COVID unit for activities; we appreciate how important teamwork is, especially through these tough times."

> *"Remaining positive is key to survival. Always be good stewards of resources. Learn to be flexible in everything."*

It is time to take bold steps to broadly scale educational and technical assistance in the form of QI initiatives that aim to make person-centered care the norm throughout the residential long-term care sector. These initiatives can take multiple forms, and many experts and organizations can be involved. For example, as providers, policymakers, and regulators look for ways to revive the long-term care sector, the national demonstration authority in Sec. 6114 of the Affordable Care Act is readily available to be taken forward in 2022 and 2023. Such a demonstration could crystallize understanding of those best practices most likely to improve both quality of care and quality of life for millions of residents living in nursing homes.

Culture change homes routinely go well beyond what is currently required by minimum regulatory standards, reflecting an understanding that in residential settings, cultivating quality of life is as important as providing quality of care. This entails making resident choice and preferences part of the quality equation. Considering quality of care and quality of life equally important could allow regulators to see how well nursing homes balance an individual's safety risks (both upside and downside risks) and a recognition of residents' essential autonomy – a balance that is fundamentally important to those being cared for – regardless of setting.

Additionally, this survey supports previous findings that improved infection control is aided by private rooms and bathrooms. The Administration has charged CMS with exploring how to phase out rooms with three or more residents and take steps to shift to private rooms. Of note, The Green House Project small homes feature private rooms and bathrooms for all residents and performed significantly better during the pandemic with 2020 and 2021 COVID-19 infection rates per 1000 residents at 48% and 40% of the national nursing home infection rates in those years, respectively. COVID-19 deaths were lower in Green House homes as well with COVID-19 deaths per 1000 residents at roughly one-third of the rate for nursing homes nationally in 2020 and 2021.

The National Academies of Sciences, Engineering, and Medicine (NASEM) went further than the Administration in its April 2022 report on nursing home quality. Recommendation 1E of this report includes prioritizing private bedrooms and bathrooms and ensuring that *all* new builds are single-

occupancy rooms with private bathrooms. The committee's vision is that, "Nursing home residents receive care in a safe environment that honors their values and preferences, addresses goals of care, promotes equity, and assesses the benefits and risks of care and treatments."[5] The report also emphasizes the need to move to person-centered care in nursing homes in every chapter, recognizing that this care focus is at the heart of culture change, and that widespread adoption of these practices can and should be accelerated. The NASEM report further identified four key areas essential for high quality nursing home care:

- Care that is effective, timely, and equitable;
- Communication that is caring and responsive to residents, families, providers, and community;
- Empowered staff who are knowledgeable, consistent, compassionate, and team-based and who follow through with care; and
- An environment that is calm and active (in a way that aligns with residents' needs), friendly, and pleasant; that has community involvement; and that is home-like.[6]

In order to draw individuals into healthcare jobs in long-term care settings and to minimize turnover, there must be a greater focus on engaging and empowering employees in decision-making that affects their work and engaging and empowering residents in decision-making that affects their lives. It is essential that more emphasis is placed on staff and residents knowing one another well to lessen conflict and loneliness and to increase connectedness and kindness. The pandemic has revealed that top-down decisions made by people far removed from the lives of residents does not work, can be detrimental to the work environment, and is driving employees away from the sector. When employees have a voice, choice, and influence over their work; when they know their peers well; when there is positive teamwork; when they have the skills and support they need to be their best; they come to work, and staff turnover decreases. Organizational systems must be designed to be person-centered for the employees just as they should be for the residents. Flattening organizational hierarchies and leadership strategies such as mentoring and coaching rather than micromanaging are two ways to make this happen. Policies, procedures, and practices must enable flexibility and individualized approaches to care to fit each staff member and resident rather than one-size-fits-all.

Concluding Observations

In retrospect, warning signs were clear that the U.S. nursing home system was unprepared for the challenges of COVID-19. For example, the Government Accountability Office found that pre-pandemic, "infection prevention and control deficiencies were the most common type of deficiency cited in surveyed nursing homes, with most nursing homes having an infection prevention and control deficiency cited in one or more years from 2013 through 2017 (13,299 nursing homes, or 82 percent of all surveyed. And a piece by Charlene Harrington et al published in *Health Services Insights* in 2020 concluded that "most nursing homes do not provide sufficient staffing to ensure basic quality. More than half of U.S. nursing homes were found to have lower RN, CNA, and total nurse staffing levels than those recommended by experts and one quarter of nursing homes had dangerously low staffing (below 3.53 total nursing hours) in 2014, and 75% of nursing homes almost never met the CMS expected RN staffing levels based on resident acuity in the 2017 to 2018 period."

Yet not all nursing homes have had dire outcomes. Culture change homes showed that it was possible to maintain at least some person-centered practices during a pandemic in tandem with workforce shortages. Despite an imposed focus on safety, isolation, and infection mitigation, culture change homes fought to maintain a level of person-centeredness. Researchers and experts can analyze what was done differently at these sites, other providers can seek to emulate some of these successful practices, and policy makers can revise guidance, train surveyors, and develop incentives that spread these successful practices. It is time for culture change practices and protocols that have been developed – and are still being developed in response to evolving circumstances – to move beyond the *ad hoc* phase.

> *We can get through anything together! Constant communication is critical for residents, their families, and staff! Doing things the right way saves lives, including having and using PPE.*

Today, choosing a nursing home based on its commitment to person-centered practices is extremely difficult because these practices are not well-defined nor are they being fully captured in data even though there are clear expectations for nursing homes to implement them as part of their daily routines, e.g., in the 2017 CMS State Operations Manual. This could become an imperative if federal and state policies along with oversight entities are aligned to deliberately seek out and reinforce approaches that strengthen resident choice and experience. We urge policymakers to move swiftly to incorporate culture change learnings that can accomplish the twin goals of improving emergency preparedness and resident safety while simultaneously assisting millions to enjoy a better life in their final years.

This survey and report were supported by Altarum, Pioneer Network, Live Oak Project, The Green House Project, and The Eden Alternative.

Citations and References

1. White Paper: Advancing Equity in Nursing Homes: Resident, Family, Community Advisory Council (RFCAC) Pilot Program Proposal https://www.caltcm.org/white-paper--advancing-equity-in-nursing-homes--resident--family--community-advisory-council--rfcac--pilot-program-proposal
2. NIC Occupancy at U.S. Skilled Nursing Facilities Hits New Low - National Investment Center (nic.org)
3. NIC Occupancy at U.S. Skilled Nursing Facilities Hits New Low - National Investment Center (nic.org)
4. Page 2, Skilled Nursing Monthly Report: Monthly Skilled Nursing Report - February 2022 (nicmapvision.com)
5. Box S-1 of the report, page 5 – NASEM report: The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Residents, Families, and Staff (2022)
6. NASEM report, p. 39: The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Residents, Families, and Staff (2022)
7. Nursing Home COVID-19 Vaccination Data Dashboard | NHSN | CDC
8. Nursing Home COVID-19 Vaccination Data Dashboard | NHSN | CDC

APPENDIX A

Responses about COVID-19 vaccination rates

All but one culture change site surveyed reported their resident COVID-19 vaccination rates. Fifty-seven sites (92%) had at least 90% of residents vaccinated, with 43 sites (69%) at 95% or higher and 20 sites (32%) reporting 100% of residents vaccinated. As of the week ending March 13, 2022, the CDC reported that 87.7% of nursing home residents were vaccinated nationally.[7] Thus, in comparison to this number, the sites surveyed for this study had higher resident vaccination rates.

Current staff COVID-19 vaccination rates were lower. All but one site reported staff vaccination rates, with rates ranging from 33% to 100%. Forty-nine sites (79%) had current staff vaccination rates at 80% or higher, 38 sites (61%) had current staff vaccination rates at 90% or higher. Twenty sites (32%) reported 100% of staff were vaccinated. As of the week ending March 13, 2022, the CDC reported nursing home staff rates for complete vaccination at 88.8%.[8] In comparison, the sites surveyed for this study had lower staff vaccination rates.

APPENDIX B

Resources that can help you implement person-centered care and team-empowering care:

https://www.edenalt.org/

https://thegreenhouseproject.org/

https://www.pioneernetwork.net/

https://www.pioneernetwork.net/live-oak-project/

https://altarum.org/

Artifacts of Culture Change – https://www.pioneernetwork.net/artifacts-culture-change/

Pioneer Network Resources – https://www.pioneernetwork.net/resource/

APPENDIX C

In open-ended survey responses, culture change homes expressed a deep commitment to recovering and continuing to improve person-centered are and strengthen a team-based care culture:

Everyone matters, and we can't do this without every person!

The complete "lock down" was a huge detriment to both physical and mental health of our elders. We won't ever go back to asking elders to remain in their rooms 24/7 when there is an outbreak.

I think one of the worst things that happened was not allowing residents to have close contact with their loved ones and visitors. This definitely caused more harm and even deaths… We learned that sometimes we -- and the government -- may need to look at the whole picture and take into consideration the things that may happen to and with the residents, before setting up rules and regulations.

When down for so long, we lost music and laughter, and we need to never let that happen again.

Train a newly hired administrator in the culture of the building and mentor them even if they were a long-time administrator and "knew the job."

We will be better prepared for a future pandemic or other healthcare emergencies.

We can get through anything together! Constant communication is critical for residents, their families, and staff! Doing things the right way saves lives, including having and using PPE.

We learned the importance of rapid and frequent communication. The ease of using electronic communications has made this easier. Also, coming together as a team has been key. For example, we set up a "Covid Command Team" that makes decisions as everyone was learning. We also learned the importance of knowing and sharing information resources quickly to accomplish all the tasks that have been required.

It's important to be aware of who is coming and going from your community. Keep it open, but do consistent screening of staff, visitors, vendors, and volunteers.

We have created a clear understanding and expectation of medical staff roles and responsibilities. We maintain strong and active networks with our colleagues. Their help is invaluable.

We need to be crisis-ready all the time. We need to empower our staff and make them feel like they are part of a team. Everyone matters, and we can't do this without every person. We will take steps to educate staff who don't "get it," or discipline them out of the organization.

We learned the importance of addressing mental health needs of staff, and figuring out how to decrease burnout/PTSD. How do we bring joy to the everyday?

Remaining positive is key to survival. Always be good stewards of resources. Learn to be flexible in everything.

Keeping detailed records is helpful, e.g., the dates units were closed; the dates visitation stopped/started; the dates of positive tests for stakeholders/residents; information that keeps up with residents' belongings, which is difficult with multiple room moves. We are trying to move people less.

There is the frustration of ever-changing rules and the focused surveys have been very hard on the staff on top of all the PPE that is needed for protection.

We have improved communication about changes, i.e., visit cancellations for residents and families. We continue to provide education about Covid updates, and to promote inclusion in decision-making.

We have infection control training for all staff, and supplies are more readily available (PPE), as are private rooms.

We must be able to pivot fast, we can't do this alone, and we must advocate with government officials to try to help everyone understand the impact of decisions.

Residents have a choice of health care. No matter what information we provide re vaccine efficacy and infection control, there are families/residents who will not follow the science, and loss has resulted. It is hard to see preventable situations occur with tragic results. On the positive side, residents are resourceful and resilient. As one elderly gentleman said, "This is not going to take me down -- 30 years as a fireman and the Korean War didn't -- so COVID has no business messing with me and my caregivers."

Early on when the elders were not allowed visitors, we stayed on top of those who were showing signs of decline and worked to ensure they were able to have at least one family member visit for compassionate care (we followed guidelines as provided by the State early on). Communication with the family members was amazing and they truly appreciated our constant updates. Our biggest lesson learned was constantly living in fear of having a severe outbreak in the community. So as a group we got together and decided we cannot keep walking on eggshells and living in fear.... what can we do? We all decided that we needed to show love and compassion each day.

We distance people/staff and residents at first sign of outbreak. We wash everything daily! You can never over-communicate. You, your team, and your elders are stronger than you think.

We have developed creative ways to encourage residents to wear masks when outside their rooms; we have increased cleaning of high-touch areas; we have a plan in place for residents in the COVID unit for activities; we appreciate how important teamwork is, especially through these tough times.

Educate staff, residents and families to ensure cooperation. Take care of your team. Don't allow staff to work sick.

APPENDIX D

Summary of Nursing Home Reform Initiatives Announced by HHS and NASEM Parallel Recommendations

Topic: Quality – Promote Single Occupancy Rooms			
Agency or Other Entity	**Specific Agency Responsibility with comments**	**NASEM Report**	**Partners and Collaborators**
Agency/CMS	CMS on strategy to move to single occupancy rooms, HUD (possibly) if needed to monitor quality of new single occupancy rooms or to provide additional evidence on problematic nature of double and triple occupancy rooms. Define minimum parameters for single occupancy rooms (size, monitoring systems, own bathrooms, etc.).	**Recommendation 1E** (Pages 507-508): Nursing home owners, with the support of federal and state governmental agencies, should construct and reconfigure (renovate) nursing homes to provide smaller, more home-like environments and/or smaller units within larger nursing homes that promote infection control and person-centered care and activities. • The design of these nursing homes should include consideration for the following characteristics: unit size, activity and dining space by unit, a readily accessible therapeutic outdoor area, an open kitchen, a staff work area, and entrances and exits. • Smaller units should be designed to have the flexibility to address a range of resident care and rehabilitation needs. • New designs should prioritize private bedrooms and bathrooms. • This shift to more home-like settings should be implemented as part of a broader effort to integrate the principles of culture change, such as staff empowerment, consistent staff assignment, and person-centered care practices, into the management and care provided within these settings	National Association of Healthcare Assistants Hartford Institute for Geriatric Nursing National Gerontological Nursing Association Elder Workforce Alliance NYU College of Nursing and Hartford Institute for Geriatric Nursing John A Hartford Foundation Institute for Healthcare Improvement PHI Liberty Grace Church of God and Resident-Family-Community Councils Gerontological Society of America American Geriatrics Society Association for Professionals in Infection Control and Epidemiology

Topic: Accountability – Technical Assistance to Nursing Homes			
Agency or Other Entity	**Specific Agency Responsibility with comments**	**NASEM Report**	**Partners and Collaborators**
CMS with QIOs (and others)	CMS to make quality improvement technical assistance a priority CMS to prepare and share training and best practices	**Recommendation 6E** (p. 535) CMS should allocate funds to state governments for grants to develop and operate state-based, non-profit, confidential technical assistance programs that have an ongoing and consistent focus on nursing homes. These programs should provide up-to-date, evidence-based education and guidance in best clinical and operational practices to help nursing homes implement effective continuous quality-improvement activities to improve care and nursing home operations. • CMS should create explicit standards for these programs to promote comparable programs across states. • The program should conduct ongoing analysis and reporting of effectiveness of services provided. • The program should provide services to all nursing homes in the state, with a focus on those identified as being at risk for poor performance, but also be available to those with moderate and high performance. • The program should coordinate with state surveyors/ombudsmen and receive referrals regarding facilities needing assistance, but maintain the confidentiality of the details of the services provided to each facility (notwithstanding the mandated reporting requirements in each state regarding resident abuse and neglect). • The programs should consider partnering with relevant academic institutions of higher education, such as colleges of nursing, medicine, social work, rehabilitation services, and others.	NAPSA Stratis Health Harvard University Brandeis University AARP QINs/QIOs National Assn of LTC Administrator Boards UNITE (United Nursing Homes in Tribal Excellence) Live Oak Project Culture Change Administrators assembled by Pioneer/ GHP NADONA Institute for Healthcare Improvement Liberty Grace Church of God and Resident-Family-Community Councils American Geriatrics Society Community Catalyst LeadingAge Center for Workforce Solutions Association for Gerontology and Human Development in Historically Black Colleges and Universities National Caucus and Center on Black Aging National Hispanic Council on Aging

Topic: Transparency – Enhance Nursing Care Compare			
Agency or Other Entity	**Specific Agency Responsibility with comments**	**NASEM Report**	**Partners and Collaborators**
CMS and Congress	CMS will enhance Care Compare website: • Showing how to interpret key metrics • Make sure data is accurate • Hold facilities accountable for inaccurate data MUST DEFINE how facilities will be held accountable – this is critical. Congress called upon to give CMS authority to validate data and take enforcement action on inaccurate data.	**Recommendations 6B/6C** (p. 532-533) HHS, CMS, NIH, and AHRQ should expand and enhance existing publicly reported quality measures in Care Compare by: • Increasing the weight of staffing measures within the five-star composite rating; • Facilitating the ability to see quality performance of facilities that share common ownership (i.e., chain and other multi-facility owners) or management company; • Improving the validity of Minimum Data Set–based measures of clinical quality (e.g., better risk adjustment, auditing for accuracy, inclusion of resident preferences); and • Conducting additional testing to improve the differentiation of the five-star rating so it better distinguishes among the middle ranges of rating, not just the extremes. **Recommendation 6C:** HHS should fund development and adoption of new nursing home measures to Care Compare related to: • Palliative care and end-of-life care; • Implementation of the resident's care plan; • Receipt of care that aligns with resident's goals and the attainment of those goals; • Staff well-being and satisfaction; • Psychosocial and behavioral health; and structural measures (e.g., HIT adoption and interoperability; the percentage of single occupancy rooms; emergency preparedness, routine training in infection prevention; emergency response management; financial performance; staff employment arrangements [e.g., full-time, part-time, contract and agency staff])	Center for Medicare Advocacy Justice in Aging LTCCC California Advocates for Nursing Home Reform NAMFCU National Association of Attorneys General (NAAG) NAPSA Stratis Health Institute for Healthcare Improvement Urban Institute Brookings Institution Consumer Reports University of California/ San Francisco Eden Alternative Association of Health Facility Survey Agencies