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Long-Term Care and the Response to COVID-19

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The COVID-19 pandemic has had far-reaching consequences on how the healthcare community approaches the delivery of care. Traditional care structures require frequent points of physical interaction, putting both patients and providers at risk for virus exposure. As such, policymakers and providers must find a balance between ensuring that patients receive needed care and ensuring the safety of both the patient and the healthcare workforce. Long-term care (LTC) facilities in particular provide a unique and challenging setting for meeting these goals as these facilities care for individuals most vulnerable to the effects of COVID-19.[1,2,3] As a result, LTC facilities have been widely affected by COVID-19. More than 1 in 4 nursing homes have experienced a case of COVID-19,[4] with residents and staff of LTC facilities accounting for approximately 10% of total cases in the United States and a disproportionate percentage of deaths, with some estimates placing the number at close to 40% of all deaths in the United States. [2,5,6]

In addition to the vulnerability of their residents, LTC facilities are encountering numerous challenges that have become increasingly apparent as the pandemic has progressed. In this Perspective, we address the impact of visitor restrictions, staffing turnover, and infection prevention and control expertise on the quality of care and safety of both residents and staff in LTC facilities.

Visitor Restrictions

In an effort to reduce the spread of COVID-19 infection, the Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) recommend placing residents infected, or suspected of being infected, on transmission-based precautions.[7] This can include isolation from other residents and limited family interaction. However, facilities will waive this policy in compassionate care cases. While this is an effective practice for limiting the spread of infection during an outbreak,[8] LTC providers must address the unintended harms that result from this prevention approach. Residents in isolation report feeling grief, loneliness, and fear.[3,4] Particularly among residents with dementia or other declined neurological function, it is challenging for them to understand the necessity of isolation, departures from usual routines, why they are unable to visit with their family members, and to voluntarily comply with isolation procedures.[9]

LTC facilities are designed as community-based structures,[2] with an emphasis placed on the benefit individuals can gain from social interaction and enhanced mobility, such as reduced risk of falls and pressure ulcers. Additionally, many LTC residents rely on visits from family members for meaningful social interaction or to supplement aspects of their care, such as eating meals with loved ones.[10] Absent these interactions, increased feelings of loneliness are a critical risk factor for negative health outcomes, and are directly linked to cognitive decline and depression.[3,4] Some research has also indicated that feelings of loneliness may also be a risk factor for recurrent stroke and mortality. Anecdotally, providers and families worry loneliness may be more deadly to residents than the virus.[11,2]

To address resident isolation stemming from visitor restrictions, facilities can encourage family members and friends of residents to consider other ways to "visit." This could include connecting via video chat, regularly calling loved ones, sending letters or cards, and coming for window visits wherever possible. Additionally, staff can be encouraged to: wear supplemental nametags in large, clear fonts easily seen by people who are blind or have low vision, to help residents make a connection with staff members[3] in masks, or to "adopt" a resident so that there is a designated staff member tasked with engaging with them and monitoring for any signs of decline.[2] Facilities should reference CMS guidance on how to safely facilitate in-person visitation beyond compassionate care circumstances to address the psychosocial needs of residents, and on the use of Civil Money Penalty (CMP) funds to purchase communication devices to allow residents to connect with family members. Additionally, guidance includes direction regarding the safe reopening of nursing facilities, greatly alleviating visitor restrictions.

Staffing Turnover

Staff turnover, particularly among certified nursing assistant (CNAs) is an unfortunate characteristic of LTC facilities – persistent long before the pandemic.[12,13] However, the COVID-19 pandemic has exposed problems and weaknesses associated with staffing shortages and chronic turnover. Particularly with residents moving into isolation, care has become more labor-intensive, exacerbating shortages and making it difficult to maintain proper hygiene practices, such as frequent handwashing and replacing personal protective equipment.[13] Furthermore, continuous turnover has created an environment where it is difficult to establish and maintain practices for high-quality care, including in infection control practices, and challenging to ensure all staff receive adequate training.[13] Staff turnover has continued throughout the pandemic due to: staff feeling overwhelmed with their care duties and infection control responsibilities, low morale, worry about protecting themselves and their families,[14,15] and discomfort with continuous testing. These staffing issues not only exacerbate concerns regarding appropriate infection control and prevention related to COVID-19, but also limit a facility's capacity to mitigate safety risks associated with usual care needs for this patient population, such as falls and pressure ulcers. Maintaining equipment like eyeglasses, hearing aids, walkers and other assistive devices has also shifted from family to staff; without these vital sensory and movement aids, residents' isolation further increases.

While the pandemic has emphasized that there are many complex issues associated with LTC facility staffing that need to be addressed in the long-term, there are several immediate steps facilities can take that may partially alleviate staff turnover. For example, facilities can ensure staff understand that they are appreciated and emphasize the valuable and essential role they play, which may include offering staff hazard pay.[16] Additionally, as proper social distancing and consistent use of masks are unfamiliar concepts

to many team members, facilities should find opportunities to provide guidance as to how they can keep themselves, their families, their communities and the residents they care for safe.

Infection Prevention and Control Expertise

CMS requires that LTC facilities who participate in Medicare or Medicaid have in place an Infection Prevention and Control Program and an Infection Preventionist (IP) at least part-time with specific policies and procedures that address surveillance, reporting, standard and transmission-based precautions, and resident isolation.[17] CMS and the CDC developed an infection prevention training that is available online, along with a requirements compliance facility self-assessment survey tool and a multitude of infection prevention and control resources. While these are incredibly valuable resources for LTC facilities and CMS requirements have been successful at improving infection control practices,[3] research prior to the COVID-19 outbreak suggests that homes struggled to meet infection control standards.[2] Staff turnover makes it challenging to maintain infection prevention expertise within individual facilities. Rural LTC facilities in particular may suffer from a dearth of infection prevention expertise. Weaknesses in infection prevention and control expertise, coupled with the unprecedented nature of a novel, highly infectious disease, has created a challenging obstacle for LTC facilities to overcome and may be contributing to the high rates of infection among both residents and staff. While management of the infection has improved as the pandemic has continued and facilities have learned more regarding effective, best practices for minimizing spread, implementation is not universal.

In the summer of 2020, HHS invested $2.5 billion from the Provider Relief Fund (PRF) to support nursing homes in providing PPE, increasing COVID-19 testing, and supporting their workforce. Additionally, HHS, through the Agency for Healthcare Research and Quality, is partnering with the University of New Mexico's ECHO Institute in launching a National Nursing Home COVID-19 Action Network to provide free training and mentorship to nursing homes across the country to increase the implementation of evidence-based infection prevention and safety practices to protect residents and staff. CMS has also developed a best practices toolkit for nursing homes to help them address the COVID-19 epidemic. The toolkit covers topics such as infection control and workforce/staffing. Member association forums can be a powerful resource for facilities to gather infection control best practices that can be practically applied to the care home setting. Frontline staff who have successfully managed containment of the virus at their facility should be encouraged to share their insights through these channels.

The COVID-19 pandemic has brought new challenges to LTC facilities. The stress imposed by the pandemic created cracks where otherwise unidentified weaknesses existed and more permanent structural and programmatic change is needed. As we look beyond the pandemic response, there is an opportunity for providers and policy makers to consider what comes next as the LTC facility community hopes to learn from this unprecedented event. Reports from bodies such as the Coronavirus Commission on Safety and Quality in Nursing Homes provide key recommendations and discrete calls to further action that can help to ensure nursing homes are better prepared to handle the continued effects of COVID-19 and any future crises.

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