White Paper

Advancing Equity in Nursing Homes: Resident, Family, Community Advisory Council (RFCAC) Pilot Program Proposal

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The COVID-19 Pandemic has exposed significant inequities in nursing homes across the country. We are proposing to develop a pilot program that combines data driven community engagement with facility accountability that could then be implemented by the QIN-QIOs.

The recently passed American Rescue Plan Act provides $200 million for the development and dissemination of COVID-19 prevention protocols in conjunction with quality improvement organizations.[1] We've been through four waves of the pandemic in the United States and the third wave was particularly devastating to nursing homes, with over 6000 deaths per week in December, despite the considerable efforts that had already been focused on improving infection control and prevention in nursing homes.[2,3]

We continue to lag behind in addressing and understanding the significant disparities that exist in nursing home care. Prior to the pandemic there was evidence of the impact of disparities in nursing homes.[4] One study demonstrated lower rates of pressure ulcer healing in black nursing home residents.[5] Racial and ethnic minorities tend to reside in nursing homes with limited financial resources, low staffing levels and a high number of deficiencies. One study showed that only 9% of white nursing home residents live in "lower-tier" homes.[6] That is compared to an estimated 40% of black nursing home residents. What that means is that black Americans are three-times more likely to reside in a poor-performing or lower quality nursing home than white Americans. It should come as no surprise that a recent study found that nursing homes with the highest proportions of non-White residents experienced COVID-19 death counts that were 3.3-fold higher than those in facilities with the highest proportions of White residents.[7] There is a litany of evidence-based literature documenting negative outcomes during the pandemic that can be related to disparities.[8,9] Garcia et al recently addressed this issue and stated, "While the ongoing COVID-19 pandemic is an unprecedented crisis, the racial/ethnic health inequalities it has exposed are longstanding and deeply rooted in American society. Increased risk of exposure to the virus, weathering processes, and reduced health care quality and access are key proximate mechanisms that explain *how* the COVID- 19 outbreak is disproportionately harming older Black and Latinx adults."[10]

As nursing home deaths represented on average 35% of COVID-19 deaths, there were some states that had over 75% of COVID-19 deaths represented by nursing home residents pre-vaccine. Other states post-vaccine introduction still had over 65% of all deaths from nursing home residents. 1 in 5 nursing home residents that tested positive for COVID, died from COVID according to the Centers for Medicare and Medicaid Services.[11] For over 15 months during the pandemic, most nursing homes were on complete lockdown and did not allow for family, friends, or clergy visitation and most nursing home residents were isolated and confined to their rooms. The effects of the isolation, obscurity, secrecy and lockdowns have had short and long-term effects on the residents' physical and mental well-being.[12,13]

The COVID-19 pandemic has exposed many opportunities for improvements in pandemic planning, gaps in services in healthcare in general, and in nursing homes specifically. In minority communities across the country trusted sources that include churches and community

leaders and organizations have led vaccine efforts that addressed access and equity. The National Minority Quality Forum (NMQF), in working with the Centers of Disease Control, is creating options to continue to build on partnerships and methods created during this pandemic to improve minority health. NMQF is seeking to expand a successful disparities reduction vaccine model established in Baltimore by Dr. Terris King in partnership with the Johns Hopkins International Vaccine Center and Baltimore Cities Health Department.[14] This model improved vaccination rates by 13%. While efforts to address the impact of disparities on vaccination rates in nursing homes is important, this must only serve as an entry point into addressing the broader issue of poor quality that has and will continue to be related to disparities in nursing homes across the country. This is why we believe that there is an opportunity to more effectively utilize the American Rescue Plan Act by developing a pilot program that integrates community leadership and satisfaction metrics into healthcare improvement efforts in order to address the serious issue of disparities and inequities in nursing home care.

A Prime Opportunity

While strengthening the voices of residents and families we must promote transparency and address these critical issues as we allocate funds to improve care in nursing homes. This is an opportunity to fully recognize the health equity gap that exists in nursing homes. Improving nursing home quality has been designated by CMS in a 12th "statement of work" as a key area of focus for QIN-QIO's through July 2024.[15] This focus encompasses reducing hospital readmissions, decreasing opioid utilization, improving overall nursing home quality, reducing healthcare-related infections, and reducing adverse drug events. Previous "scopes of work" have had a similar focus. The COVID-19 pandemic has painfully demonstrated the fact that previous efforts have not achieved the desired goals. It has also demonstrated the need for broader partnerships and transparency in order to reduce inequities. It is time to give the QIN-QIOs implementable and sustainable tools that will effectively guide quality improvement efforts in ways that can help reduce the disparities in nursing homes.

Recent studies have looked at the impact of large chain and for-profit status as influencers to nursing home quality.[16,17] 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 has three major responsibilities: appointing the administrator, approving facility policies and oversight of the facility QAPI program. The Governing Body is a key element by which to bring accountability for the quality of care in a nursing home. We believe that any effort to improve quality should incorporate this already built-in accountability opportunity.

A recent study pointed out that delivering person centered care to nursing home residents must involve knowledge not only of the individual residents, but of their

families, and by extension the communities they live in.[18] Community-based participatory research is a tool that has been demonstrated to positively impact attempts to address disparities.[19] We believe that this same concept can and should be utilized in nursing homes. In order for the American Rescue Plan Act funding to be effectively utilized we must not only give the QIN-QIOs the support and direction that will lead to sustainable success and attribution, but also create tools that can increase accountability for improving the sustainability of their efforts. It is critical that nursing homes and their governing bodies both be responsive and accountable to the residents and their community. We believe that enhancing the existing role of resident councils to incorporate community members can bring about this accountability. Developing data driven satisfaction metrics that reflects the concerns of families and community members will be a critical component in firmly establishing an accountable relationship between the nursing home Governing Body and the surrounding community. During the 9th SOW and beyond Congress has continually focused on attribution as it relates to the Quality Innovation Networks-Quality Improvement Organizations (QIN-QIOs). The COVID-19 pandemic has demonstrated that additional measures are necessary in order to demonstrate attribution in relation to nursing homes that care for high percentage of minorities. A significant reduction in Nursing Home Health Disparities would highlight increased Quality Improvement attribution by the QIN-QIOs.

The following are recommendations and strategies that the CMS Center for Clinical Standards & Quality should implement:

- **Pilot Resident, Family, Community Advisory Councils (RFCACs)**
- **Minority Serving Nursing Home Quality Symposium**
- **Developing Data Driven Satisfaction Metrics and Incorporating New Technologies**
- Post-acute and Long Term Care Medicine Subject Matter Experts for QIOs
- Incentives and Penalties for Failing to Meet Quality Measures
- Training and recruitment of Quality Improvement Specialists that have Certificates of Completion for QI Programs and/or Health Disparities Reduction Focus
- Leadership Quality and Disparities Reduction Training
- Quality Assessment and Performance Improvement (QAPI)
- Infection Control Preventionist (ICP)

Resident, Family, Community Councils (RFCACs)

The impact of the COVID-19 pandemic on both younger and older people of color must be prioritized. In order to do this the voices of residents, caregivers and communities must be heard. Resident Councils and Family Councils in nursing homes were first introduced under The Nursing Home Reform Law, the Omnibus Reconciliation Act of 1982 and 1987 (42 CFR sec.483.15(c); Public Law 100-203, Social Security Act). The Family Councils do not need to include any staff from the nursing home and the nursing home must provide them space and allow to meet within the nursing home. Some nursing homes have both family and resident Councils, but it is reported that the majority of nursing homes only have resident councils. We propose improving upon this concept by creating an entity that the facility's Governing Body would need to be accountable to. Expanding support with community members would

strengthen the voice of residents and families.[20] We suggest that CMS require facilities to implement Resident, Family, Community Advisory Councils (RFCACs). Not only will community members know what is going on inside a nursing home, they will also be able to provide community support.

The engagement of local churches is one major opportunity. There is precedent for such councils in Federally Quality Health Centers (FQHCs). QIN-QIOs could also provide family training in churches to teach families how to advocate and participate in the healthcare decisions of their family members who are residents in nursing homes. The QIN-QIOs should also teach these families how to identify quality care from a non-clinical perspective. This type of self-efficacy building process given by RFCACs for communities and families that are often vulnerable could prove valuable in focusing on quality improvement efforts. Community council (RFCAC) members could meet in churches or other trusted sources for nursing home education and leadership support.

The Iowa Healthcare Collaborative (IHC) is presently designing education programs for Patient and Family Advisory Councils in critical access and rural hospitals and already has them in place in medium and larger size hospitals and FQHCs. Part of the approach is not only preparing for the patient and their families to have a level setting knowledge, but also to work with other providers so they understand the benefits they can derive from a Patient and Family Advisory Council (PFAC). This is being done in rural and critical access hospitals as the majority of urban and semi-urban hospitals have PFACs. Follow up will be important in relation to sustaining and integrating the RFCAC into quality and safety initiatives. Nursing homes will be able to use the RFCAC as an opportunity to improve care. It will demonstrate that they are being responsive to residents, family and the community. It will also improve the processes and outcomes of care and support for residents.

HRSA has a well structured model of governance that requires 51% or greater of an FQHC Board be comprised of patients of the FQHC and has strict requirements that must be met and documented to HRSA. This is to assure that the voice of the patients are heard. The requirements and a checklist are included in the HRSA Health Center Program Compliance Manual.[21] There have been a few studies on the Governance Model of FQHCs and they all point to how it is a community centered model and is highly effective.[22]

The challenge for the ongoing support and formation of family councils is that many nursing home residents have no close family nearby and no children. According to the National Center for Health Statistics in 2012, more than 50 percent of nursing home residents have no close relatives, and 46 percent have no living children. We expect that this rate is even higher among minorities. This would illuminate the reasons and rationale for a RFCAC pilot along with significant emphasis on disparities reduction to reduce inequities.

51% or more of the Board of an FQHC must be patients and the remaining must be community members. This allows for more accountability and also support from the local community.[23] This group could also be used to expand the efforts of families that aim to keep their elderly

parents at home. In order to bring the support and voice of the community to assist residents and families, we are suggesting that 2 to 5 local community residents serve on the Resident or Family Council to provide continuity and to be the objective ears and eyes of what is transpiring in nursing homes.

There are currently no restrictions that would prevent a nursing home resident or family member from asking a community member to be a part of either council. However, there is nothing that states the nursing home staff must listen to the community member, unless it is voiced by the Council. In our model the RFCAC must be heard, community member involvement will be essential, and the council should have an impact on the facility leadership performance appraisal and bonus opportunities. For this reason, we also suggest that there be an official reporting line between the RFCAC and the facility Governing Body.

Minority Serving Nursing Home Quality Improvement Symposium

During this symposium the purpose and early results of the pilot could be provided. In fact, in order to function from a Human Centered Design perspective nursing homes with 60 percent or more of minority residents could be invited to contribute their ideas to the structure of the pilot. This is a prime opportunity to collaborate with the Ombudsman program. The increased focus on RFCACs is consistent with the goals and purpose of the long term care ombudsman program. A hybrid session could be provided to include select minority serving nursing home leaders in both an in-person discussion as well as meeting virtually with their leadership team. Nursing home leadership teams could be given specific areas to comment upon including their most significant challenges, greatest opportunities for improvement, barriers in establishing councils and disparities reduction strategies. The findings from this symposium could be used to finalize the structure of the pilot initially and a final symposium would be given to produce the final results and to gather implementation recommendations.

Developing Data Driven Satisfaction Metrics and Incorporating New Technologies

Nursing homes must be challenged to use Artificial Intelligence, IOT, Integrated System decision making and Human Centered Design (HCD). Artificial Intelligence must be focused on delivering person centered care and cannot be used to exacerbate disparities. HCD can be used starting with families of residents followed by frontline nursing home staff who in many cases know how bad it is and what is needed to make things better. QIN-QIOs need to provide training in cutting edge methods to address the issues of this very specialized and vulnerable population. We also believe that there is an opportunity to develop and utilize analytics that focus on resident and family satisfaction, as well as metrics that correspond to successful leadership skills. This is why we are incorporating the development of data driven resident, family and community satisfaction metrics into our pilot. We believe that such metrics will provide critical feedback and information to both consumers, community members and surveyors.

Post-acute and Long Term Care Medicine Subject Matter Experts for QIOs

While CMS has considerable expertise in geriatrics and post-acute and long term care medicine, it has been our collective experience that such expertise is often lacking within the QIN-QIOs themselves. Subject matter expert driven guidance will be critical to the quality improvement

organizations who will be tasked with the use of these funds. Throughout the pandemic, there are many examples of this having an impact. Examples include the development of testing and visitation guidance. [24,25]

Incentives and Penalties for Failing to Meet Quality Measures

Nursing homes must be required to participate. It should not be voluntary and QIN-QIOs should not have to spend time and energy recruiting facilities. The recruitment process uses up valuable resources. Furthermore, being part of quality improvement efforts through the QIN-QIOs can't be an "if," but rather needs to be a "must." Incentives for achieving a certain standard could be applied. Additionally, penalties should be incurred if facilities do not participate to the fullest extent or fail to meet a specific pre-determined quality measure. Considering that the impact of insufficient quality efforts is directly related to resident outcomes, the most impactful penalty would be limitations on admissions.

Training and Recruitment of Quality Improvement Specialists with Certification or Certificates of Completion and/or Health Disparities Reduction Focus

Sustainability is key. Otherwise, as soon as the focus goes away, things go back to the way they were before the QIO intervened. Programs that spoon feed the participants and do not develop their skills to lead initiatives to improve care ultimately show a decline in improvements. One example of this was a Special Innovation Project in Illinois and Iowa to develop an on-line training for nursing home staff to take. The administrators were open and honest and said their biggest challenge was staffing and the position of the person in charge of quality was typically a nurse or LPN that was assigned the responsibility. Few had any formal training or education in Quality Improvement (QI), as they said, 'there is no time for education.' Moreover, these positions had significant turnover and then they would just give the position to the next person in line for a little bump in pay. On-line modules were developed and 300 nursing home staff did the on-line training and received a certificate of completion. The pre and post tests showed a remarkable improvement in knowledge and how to apply QI.
The result of the effort was that, in Illinois, nursing homes recruited QI staff that had this certificate of completion. But similar to many other QIO initiatives, without support, when the funding ran out, the initiative died. We must require ongoing QI expertise in order to achieve sustainability.

Leadership Training Based on Quality Improvement and Health Disparities Reduction

The importance of nursing home staff turnover as it relates to quality is well documented.[26] A 2009 study demonstrated a significant correlation between nursing home administrators with a consensus leadership style and lower staff turnover.[27] In alignment with this CMS has shown that consistent quality leadership is essential to sustained quality improvement. Despite the evidence and awareness, effective leadership competencies are still woefully lacking in the majority of nursing homes. A recent review highlights the paucity of data available on how to improve this ongoing deficiency.[28] Another recent study demonstrated the impact that organizational structure can have on facility administrators and their ability to implement quality improvement efforts.[29] The Covid-19 pandemic has highlighted the importance of immediately focusing on leadership training if we expect quality improvement efforts to be

successful. While individual leadership and management training is essential in nursing homes, training related to team-based leadership is of particular value.[30] While TeamSTEPPS was included in CDI efforts during the 11th Scope of Work, there was very little uptake on this important training. Nursing home administrators and directors of nursing alike are not well trained to lead and manage what are essentially "mini-hospitals." Similarly, the nursing home leadership team must literally be a team. This team would necessarily include the medical director, who by §483.75(i) is charged with the responsibility for implementation of resident care policies and the coordination of medical care in the facility. We also think that the leadership team should include the director of staff development, who has the primary education and training responsibility in the facility. Without addressing the critical issue of team leadership training, we fear that quality improvement efforts will continue to flounder.

It's Time for Quality *Assessment* and Performance Improvement (QAPI)

QAPI has not come close to what it was ever intended to be. Paper compliance to QAPI is not acceptable, but is what many nursing homes actually practice.[31] There is a paucity of data or evidence-based literature on the effectiveness of QAPI. One recent study alluded to this challenge and suggested that we need to enhance our efforts to make QAPI effective.[32] QAPI has been a well-intentioned concept for nearly a decade, but it is time to put teeth in it. Quality assurance suggests a model that just deals with errors instead of doing a full assessment of areas of performance, which can then lead to true performance improvement. It is time to change QAPI from "Quality Assurance and Performance Improvement" to "Quality Assessment and Performance Improvement."

Full-Time Infection Control Preventionists (ICPs)

At the onset of the pandemic most nursing homes did not have adequate PPE. This reflected an ongoing lack of focus and dedication to infection prevention and control. The lack of adequate ICP staffing has been well documented.[33] In fact, proposed requirements for the facility ICP had recently been reduced.[34] We strongly believe that there must be a requirement for nursing homes to have a full-time ICP. They should eventually become certified and should have appropriate wages for the important work that they perform.

The Quality Improvement Journey

In 2003, Joshua Wiener opined that "quality of care in nursing homes is a major issue for which there is no simple solution."[35] In 2011 Chassin and Loeb wrote about the "ongoing quality improvement journey."[36] While their article was focused on hospital quality improvement efforts, the three requirements that they identified for achieving high reliability are extremely pertinent in the realm of nursing homes: Leadership, Safety Culture, and Robust Process Improvement. In the face of the COVID-19 pandemic, it is ironic that they used the example of hand hygiene as an example. It was also telling that they focused on hospitals, despite noting that the development of peer review organizations coincided with the "innovation" of prospective payment by way of diagnostic related groups in 1983. There was no mention on how this change has been directly responsible for the discharge of highly complex patients to skilled nursing facilities over the past four decades. Nor was there any attempt to point to nursing home quality improvement efforts despite an excellent review of the government's

journey to that point. Which is why the effective engagement of the QIN-QIOs is so important, especially since $200 million has now been earmarked to bolster their infection control efforts.

Conclusion

We believe that there is an opportunity to more effectively engage the QIN-QIOs in order to have a positive impact on the reduction of nursing home disparities and the delivery of quality care in nursing homes throughout the country. In particular, there needs to be a focus on facilities that highlight demonstrable inequities present in the existing system. It is time to give QIOs effective tools, the right direction, the proper resources and the ability to require accountability in order to focus on areas that can truly improve the quality of care. In order to do this, the 12th Statement of Work should be adjusted to improve the effectiveness by which the QIOs operate with nursing homes. We believe that combining some key functional recommendations and the development of data driven satisfaction metrics with the formation of Resident, Family and Community Councils provides an opportunity to create greater accountability and achieve sustainable changes in quality. We have recommended a pilot to be carried out in nursing homes in the West, Midwest and East in order to assess the effectiveness of this approach.

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