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Solving the Nursing Home Crisis

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Long-Term Care Policy after Covid-19 — Solving the Nursing Home Crisis

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Nursing homes have been caught in the crosshairs of the coronavirus pandemic. As of late April 2020, Covid-19 had claimed the lives of more than 10,000 nursing home residents and staff in the United States.¹ But U.S. nursing homes were unstable even before Covid-19 hit. They were like tinderboxes, ready to go up in flames with just a spark. The tragedy unfolding in nursing homes is the result of decades of neglect of long-term care policy.

Since the U.S. coronavirus outbreak began in a nursing home in Kirkland, Washington, more than 153,000 residents and employees of 7700 U.S. nursing homes have contracted Covid-19,¹ accounting for 35% of the country's deaths. Here, as in many other countries, nursing homes have been ill equipped to stop the spread of the virus. They lacked the resources necessary to contain the outbreak, including tests and personal protective equipment, and their staffs are routinely underpaid and undertrained. Furthermore, nursing homes were sitting ducks for Covid-19, housing people who are particularly vulnerable to poor outcomes of the virus, often in shared living quarters and communal spaces, making social distancing or isolation difficult if not impossible.

But this crisis in nursing homes is not a new problem. Long-term care in the United States has been marginalized for decades, leaving aging adults who can no longer care for themselves at home reliant on poorly funded and insufficiently monitored institutions.

Although major regulatory policies, including the Federal Nursing Home Reform Act of 1987, have attempted to address deficiencies in the quality of care, Covid-19 has highlighted the fact that better monitoring is not enough. The coronavirus has exposed and amplified a long-standing and larger problem: our failure to value and invest in a safe and effective long-term care system.

Indeed, long-term care has been sidelined in our federal social welfare policies since the 1960s, when Medicare and Medicaid created narrow and incomplete social insurance programs for such care. These programs adopted a medicalized model of care, prioritizing the use of licensed providers and institutions. This model in effect blessed nursing homes as the default provider of long-term care and made the care provided by families and others outside these licensed facilities invisible, leaving it unsupported.

Furthermore, Medicare and Medicaid were never intended to pay for the lion's share of long-term care. Medicare funds long-term care only temporarily and tangentially by covering nursing-home-based rehabilitation after a hospital discharge. Medicaid finances more than half of all long-term care for people who need help with daily activities, such as bathing, dressing, or eating, but it's available only to people who have spent down their own assets, and it still has coverage gaps.

And financing of nursing home care by both Medicare and Medicaid has been declining. Nursing homes have seen decreasing occupancy for decades, despite the aging of the U.S. population. The number of patients discharged from the hospital to a nursing home for rehabilitation has also declined.² In an effort to constrain health care spending, these patients are being sent directly home, which squeezes a critical part of nursing homes' revenue. Since

the pandemic began, short stays have all but vanished, as nursing homes turn away patients after hospital discharge, fearful of an influx of patients with Covid-19. With Medicare's recent loosening of restrictions on the use of telehealth, it is increasingly possible to support recovery from hospitalization in patients' homes, and this approach will most likely outlast the pandemic.

At the same time, states have been shifting Medicaid-funded care into people's homes, partially in response to a U.S. Supreme Court decision in *Olmstead v. L.C.* (1999) requiring that care be provided in the least restrictive setting possible. Since 2013, Medicaid has shifted a larger share of care into homes and out of nursing homes, even as it continues to underfund care in both settings.

With a decreasing census even before the pandemic, many nursing homes had little cushion to respond to a national emergency. Now they are diverting resources to stop the spread of the coronavirus, purchasing personal protective equipment and SARS-CoV-2 tests for residents and staff, for example, but most have inadequate resources for a sufficient supply of either. In the coming months, some nursing homes are likely to struggle to pay rent or their staff members and may be forced to close down or file for bankruptcy. Hundreds of thousands of nursing home residents could be displaced, which would cause huge disruptions for them and their families during an already precarious time.

Covid-19 has exposed the cracks in our tenuous system of providing and funding long-term care, and there are no easy fixes. But we believe we are well past due for comprehensive policies that take the care of aging Americans seriously and fund it accordingly and in a wider range of settings.

In the short term, nursing homes will have to be saved, because despite their vulnerabilities, they are a necessary part of any solution. Some analysts estimate that it will take up to \$15 billion in federal funds for nursing homes to survive the Covid pandemic. Recent congressional relief packages have started to address the anticipated shortfall, though experts say they will not be enough.³

Beyond the pandemic, we will have to transform the way we pay for and provide long-term care. First, we believe that Medicaid programs need to invest considerably more in care in all settings. As Medicaid has shifted long-term care into homes, funding has not kept up with that trend, meaning that more is demanded of families, who are often responsible for providing informal, unpaid care. An adult child who cares for an aging parent will face losses equivalent to \$100,000 a year, on average⁴ — roughly the same cost as a nursing-home stay. Policies that prioritize home-based care should ensure that it's paid for, whether it's provided by family members or professionals. Many families have wanted to provide care at home even before Covid, and after the pandemic many more may choose to do so if they can afford to.

Second, because caregiving at home is not feasible for many care recipients and families, we also need safe, affordable residential options. Better options can help ensure that the tragedy currently unfolding in nursing homes never happens again. Smaller-scale, high-quality group models, such as the Green House Project that has been supported by the Robert Wood Johnson Foundation, provide care in small, self-contained family-style houses with a small number of residents. Such models could offer one community-based deinstitutionalized alternative to nursing homes. The Dutch have seen positive outcomes with a small scale “Dementia Village” and models that combine childcare and long-term care. Though building out

these models requires substantial investment, we are now seeing for ourselves how critical that investment is.

Finally, we believe the United States needs to reconsider our piecemeal approach to paying for long-term care. Existing programs, such as Medicare and Medicaid, would have to fundamentally change the way they pay for long-term care to meet the needs of our aging population. More comprehensive funding through existing social insurance programs or standalone universal long-term care insurance for the entire population, are used in other countries⁵ including Japan, Germany, the Netherlands, Denmark, and France. These countries offer various better models that all value long-term care.

More funding alone is not the answer. Nor is more regulation a sufficient response. Rather, we need a combination of funding, regulation, and a new strategy that fully supports a range of institutional and noninstitutional care.

We are in a moment of crisis for nursing homes. Now should be a time of reckoning with the fundamental flaws in the organization of long-term care in this country. There are no easy fixes, but we must do better.

Disclosure forms provided by the authors are available at NEJM.org.

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