Sustainable COVID-19 Planning for Long Term Care Facilities

Playbook
October 2020

MASSACHUSETTS SENIOR CARE ASSOCIATION

CA covid-19 policy alliance

About Massachusetts Senior Care Association

The Massachusetts Senior Care Association represents a diverse set of organizations that deliver a broad spectrum of services to meet the needs of older adults and people with disabilities. Our members include nearly 400 nursing and rehabilitation facilities, assisted living residences, residential care facilities and continuing care retirement communities.

Since its founding in 1949, Mass Senior Care's mission has been to improve the quality and delivery of long-term care services in Massachusetts through research, education, and advocacy.

About the COVID-19 Policy Alliance

The COVID-19 Policy Alliance is led by a group of faculty from the MIT Sloan School of Management, and includes a team of community members and students from across the MIT campus. The Alliance has undertaken a wide range of projects to respond to COVID-19. In Massachusetts, the group has worked with the Massachusetts Senior Care Association to help long-term care facilities hire critical frontline workers, procure supplies of vital PPE, implement testing for residents and staff, and develop data analytics to guide policymakers.

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KEY CHALLENGES AND RECOMMENDED STATE POLICY AND SECTOR STRATEGIES FOR MANAGING THE NEXT WAVE OF COVID-19 IN NURSING FACILITIES

The first wave of COVID-19 has exposed substantial gaps in our nation's pandemic preparedness in nursing facilities. The rate of infection and mortality in nursing facilities is driven by many factors including the prevalence of the virus in the broader community, the vigilance of the staff outside the facility, the health status of residents, the close proximity required to care for residents, difficulty in cohorting residents to decrease transmission, limited testing, lack of consistent infection control standards, PPE supply chain challenges and costs, and substantial staffing issues (up to 20-40% vacancy rates). COVID-19 has exposed long standing deficiencies with both the financing and public policy prioritization of quality nursing facility care.

Protecting the most vulnerable populations is vital for economies to safely re-open and for effective management of the next wave of the pandemic. As state government officials and nursing facility association leaders consider ways to protect staff and residents of nursing facilities going forward, they will need to fund and build the nursing facility infrastructure needed to prevent, detect, and respond to the next wave of COVID-19 or other communicable diseases. This document provides key considerations for state and nursing facility association leaders across four key areas—testing, infection control, PPE, and workforce—as they develop strategies for this population.

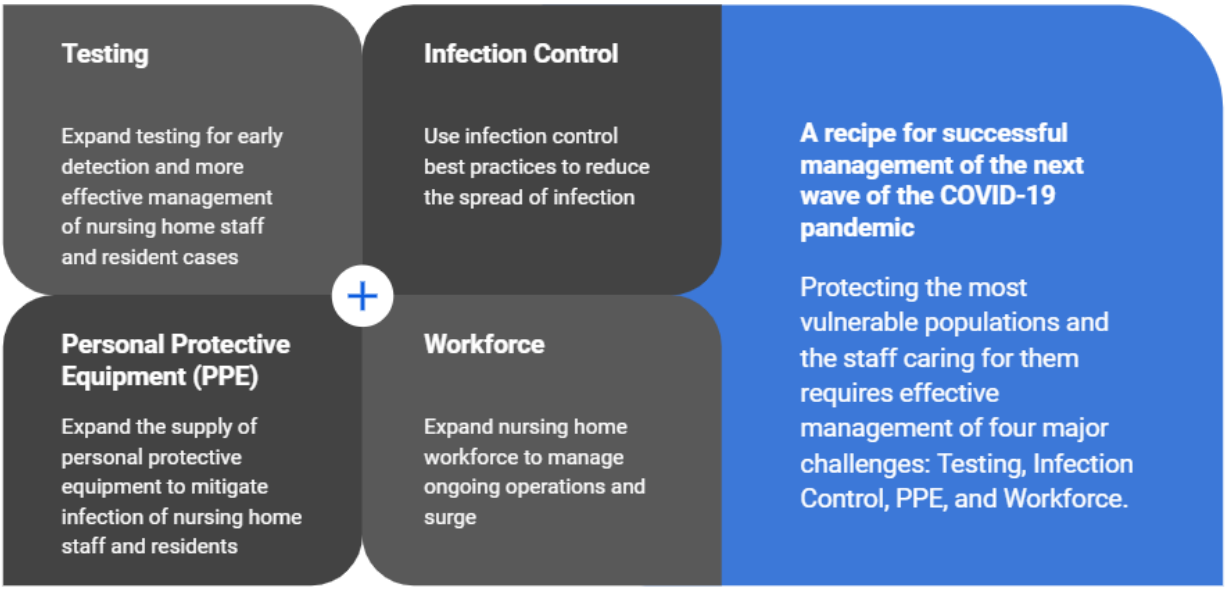

Figure 1: Overview of four challenges that need to be addressed for successful management of the next wave of the COVID-19 pandemic.

High Level Review of Considerations for State and Nursing Facility Association Leaders (Figure 1)

***Challenge I*: Testing:** Expand testing for early detection and more effective management of nursing facility staff and resident cases.

1. Gain access to timely COVID-19 testing for both baseline and surveillance testing
2. Fund testing efforts, including the requisite facility labor
3. Address temporary testing-related workforce shortages

***Challenge II*: Infection Control:** Use infection control best practices to reduce the introduction and spread of the COVID-19 virus.

1. Establishing a Best Practices Standards for Infection Prevention and Control in Nursing Facilities Guide
2. Support Ongoing Education and Training of nursing facility operators, managers and staff
3. Provide funding resources necessary for nursing facilities to provide dedicated infection control staff as well as dedicated isolation rooms/space
4. Provide Oversight of Facility Infection Control Compliance

***Challenge III*: PPE:** Expand the supply of reliable and reasonably priced personal protective equipment to mitigate infection of nursing facility staff and residents.

1. Assist nursing facilities with burn rate calculations to predict PPE demand
2. Secure reliable PPE supply
3. Use data analytics to match scarce PPE resources to most urgent needs
4. Educate facility managers and staff on PPE best practices to ensure proper use of PPE
5. Secure government funding source for PPE

***Challenge IV*: Workforce:** Expand and better prepare nursing facility workforce to manage ongoing operations and potential surge.

1. Retain existing workforce
2. Recruit new workforce
3. Build and allocate emergency pool of workers for surge infection rate scenarios
4. Secure government funding source to pay a competitive and premium wage
5. Educate workforce on infection control and PPE best practices

CHALLENGE I: TESTING

***Challenge I*: Testing:** Expand testing for early detection and more effective management of nursing facility staff and resident cases (Figure 2).

Overview: Many states, including Massachusetts, have focused on performing baseline PCR testing of nursing facility residents and staff. Baseline testing provides an important point-in-time perspective on who has the virus and has revealed a high number of asymptomatic positive residents and staff. Asymptomatic staff are required to quarantine at home for approximately two weeks. Therefore, an emergency staffing program needs to be a crucial component of any testing strategy. In addition, due to the dynamic spread of the virus, baseline testing must be supplemented by repeat surveillance testing. Surveillance testing can inform implementation of infection control practices and help facilities effectively manage PPE usage and supply. Access to government-funded PCR testing with fast test-to-result turnaround times is critical to managing and containing the spread of infection among nursing facility staff and residents. In July 2020, CMS launched a program to equip each nursing facility in the nation with an antigen point of care testing machine. This is expected to be a significant and important action in reducing the spread of COVID-19 and further protecting nursing facility residents and staff.

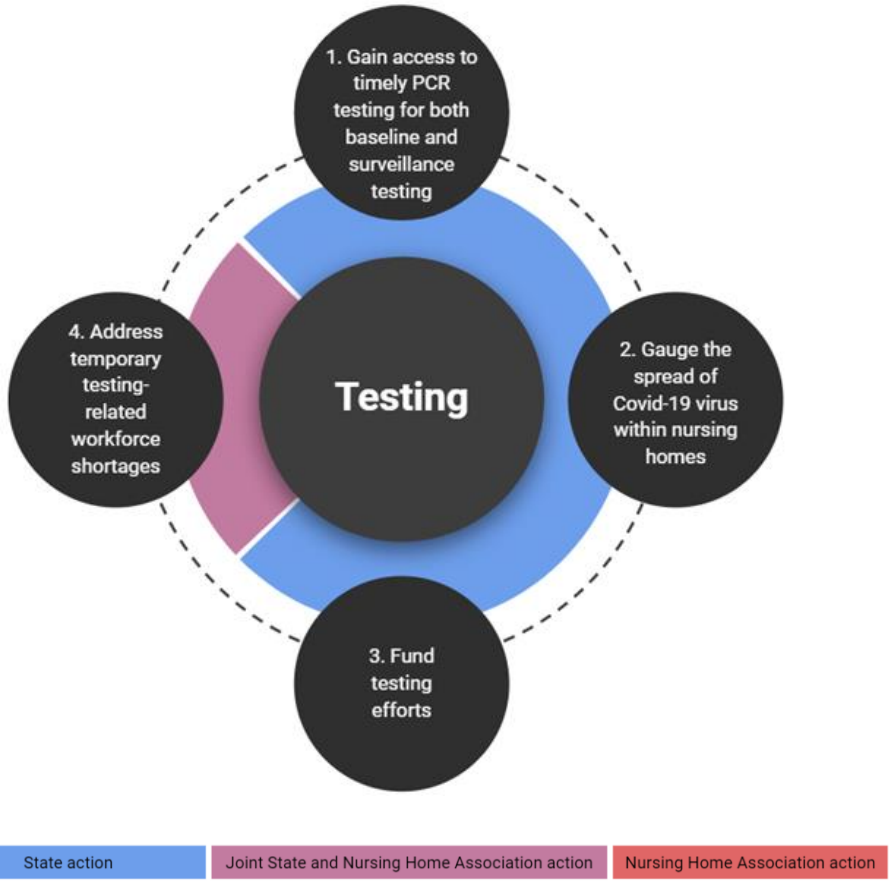

Figure 2: State and Nursing Home Association actions to address testing challenges.

Objective: Expand testing for early detection and more effective management of nursing facility staff and resident cases.

1. **Gain access to timely PCR testing for both baseline and surveillance testing.**
    i. Partner with private labs and academia to explore alternative test kit sources and processing as a means to increasing testing capacity and decreasing time-to-result. *Example: In Massachusetts, Mass Senior Care is collaborating with the Broad Institute, MIT Medical, and various labs at MIT to help procure, assemble and process test kits.*

    ii. Provide access to timely tests. Fast turnaround for test results is crucial for infection control decisions. Currently, too many labs take 48-72 hours or longer to turn tests around, at which point infection may have spread dramatically. *Example: Mass Senior Care partnered with the Broad Institute, which provides test results within 24 hours, helping facilities implement infection control measures in a timely fashion.*

    iii. Prioritize nursing facilities as Point of Care tests become available to enable timely infection control interventions and alleviate long-term burden on healthcare systems.

2. **Mitigate the spread of COVID-19 virus within nursing facilities.**

    i. Support adaptive surveillance testing for nursing facility residents and staff members. Following baseline PCR testing of all nursing facility residents and staff, nursing facilities should conduct no less than weekly testing on a random sample (e.g. from different shifts and floors) of staff who have previously tested negative. If any individual tests positive, the nursing facility will revert to weekly facility-wide PCR testing of all residents and staff. This surveillance testing strategy should also be adjusted based on the prevalence of the virus in the community. *Example: In Massachusetts, Mass Senior Care and the COVID-19 Policy Alliance designed an adaptive model for testing that alternates between a sampling-based surveillance approach and an intensive testing strategy for when an outbreak is detected following the completion of a surveillance testing pilot program with over 10,000 tests in six Boston-area nursing facilities.*

    ii. Include serology in state testing programs. Serology tests provide valuable information about past infection at the facility-level, which can help guide infection control measures and forecast healthcare needs. The collection of such samples can also help researchers learn more about antibody response and potential immunity, which will be important to understanding how and when to carefully re-open long-term care facilities. *Example: In Massachusetts, Mass Senior Care partnered with the MIT-based COVID-19 Policy Alliance and Harvard School of Public Health Infectious disease experts to conduct a testing pilot at six nursing facilities. The findings of this pilot are the basis for a surveillance testing proposal the group has put forward to the State.*

    iii. Fund research on antibody response and immunity to help inform future infection control measures and testing strategies and determine when nursing facilities could safely re-open.

3. **Fund testing efforts.**

    i. Government funding for testing for nursing facility residents and staff members. States should fund baseline and adaptive surveillance testing programs that include the purchase of point of care testing devices to incentivize consistent facility testing.

4. **Address temporary testing-related workforce shortages.**

    i. Secure government funding to support paid medical leave. Regular testing of staff is critical to protect staff, their families, and nursing facility residents. However, staff may be reluctant to get tested because current guidance prohibits positive asymptomatic staff from coming to work for at least 10 days. Funding for paid medical leave could alleviate worker concerns.

    ii. Engage with temporary staffing agencies. Facilities are concerned that if all staff are tested at the same time it may lead to a staffing crisis and further impact resident care. State support to hire additional workers and provide temporary staffing could alleviate short-term staffing shortages. *Example: In Massachusetts, the state temporarily increased the cap on charges for temp agency workers and the state contracted with a team of 120 clinicians to serve as temporary workers.*

CHALLENGE II: INFECTION CONTROL

Challenge II: Infection Control: Reduce the introduction and spread of COVID-19 in nursing facilities.
Overview: Nursing facility residents are at greater risk of both developing and being severely impacted by COVID-19. In order to protect vulnerable and medically frail residents, it is critical to establish and implement evidence-based best practices for infection control in the long-term care setting that help to: a) minimize the risk of infection in individual residents, b) reduce the risk of transmission of infection among and between residents and workers, and c) reduce the risk of infection in residents related to the use of devices and procedures required in care.
To sustain the progress that nursing facilities have achieved in infection control, it will be imperative that states, together with access to testing and a stable supply of PPE, implement infection control standards based on the Centers for Disease Control and Prevention (CDC) guidelines and apply these standards uniformly across the sector.

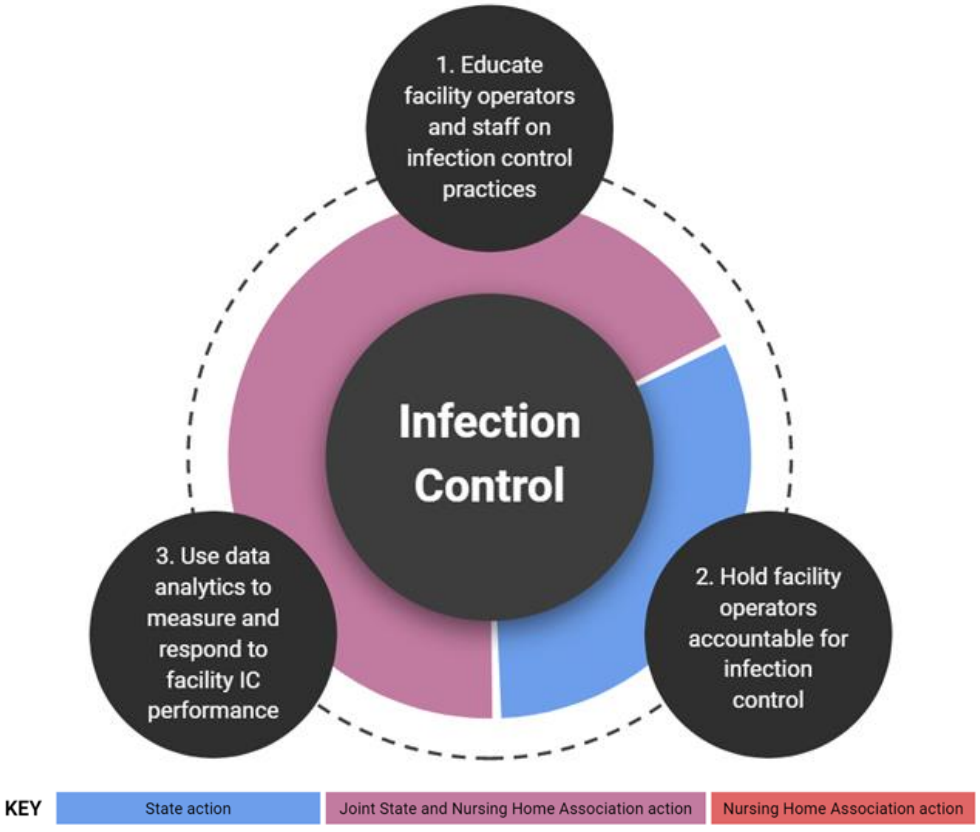

Figure 3: State and Nursing facility Association actions to address infection control challenges.

Objective: Use infection control best practices to reduce the spread of infection.
To achieve this goal, states and Nursing facility Associations should support the following initiatives:

1. Establishing a Best Practices Standards for Infection Prevention and Control in Nursing facilities Guide;

2. Support Ongoing Education and Training of nursing facility operators, managers and staff;

3. Provide funding resources necessary for nursing facilities to provide dedicated infection control staff as well as dedicated isolation rooms/space; and

4. Provide Oversight of Facility Infection Control Compliance.

1. Establishing a Best Practices Standards for Infection Prevention and Control in Nursing Facilities

i. Adopt and promote evidence-based infection control best practices/standards/metrics from the CDC and other government and specialty organizations to ensure uniform application across the state. The standards should be clear and updated, as necessary, based on evidence-based data and practices.

Example in Massachusetts: The COVID-19 Policy Alliance used a machine-learning approach to predict nursing home infections and identify COVID-19 infection drivers. The team identified nursing home county infection rates to be the strongest predictor of COVID-19 infection inside the nursing home, supporting the early identification and management of presymptomatic and asymptomatic individuals (e.g., staff) entering nursing homes from the surrounding community. [For more information on this work see: Sun, Christopher L. F., et al. "Predicting Coronavirus Disease 2019 Infection Risk and Related Risk Drivers in Nursing Homes: A Machine Learning Approach." Journal of the American Medical Directors Association, vol. 0, no. 0, Aug. 2020. www.jamda.com, doi:10.1016/j.jamda.2020.08.030.]

ii. Convene an Advisory Board of experts from academia, government, skilled nursing facilities, medical directors, hospital systems and other knowledgeable stakeholders who will advise on the development of the Best Practices Resources for Infection Prevention and Control in Nursing Facilities Guide.

Examples in Massachusetts: Mass Senior Care and Hebrew Senior Life Infection Control Command Center (MSCA/HSL) contracted with infection control consultants to educate operators, managers and staff on infection control practices and compliance with government guidelines. MSCA/HSL worked with the Executive Office of Health and Human Services to provide FAQs to nursing facility provider questions based on the state's Infection Control Competency Checklist audits.

2. **Support Ongoing Education and Training of nursing facility operators, managers and staff**

    i. Expand support for nursing facilities to access ongoing education on infection control for nursing facilities using experts in infection control.

    ii. Establish partnerships across the care continuum to ensure cross-continuum training and education, and peer to peer education on successful infection control strategies within nursing facilities.

    Examples in Massachusetts: MSCA/HSL created an Infection Control Command Center staffed by facility operators to help with infection control across all long-term care facilities in Massachusetts. The group hosted weekly webinars on infection control best practices and sustainability of these practices.

3. **Provide resources necessary for nursing facilities to provide dedicated infection control staff as well as dedicated isolation rooms/space.**

    i. Secure funding for nursing facilities to establish dedicated infection control staff whose primary role, or even sole role within the facility, is to oversee the infection control practices and education within the nursing facility.

    ii. Remove barriers in the reimbursement system to ensure a sufficient number of isolation rooms to care for residents with COVID-19 as well as other communicable illnesses. The current Medicaid reimbursement system penalizes facilities for unoccupied beds or rooms. The ability to isolate residents in order to protect and reduce the spread of infection is a critical and necessary precaution, which results in a reduction in available operating beds.

4. **Provide Oversight of Facility Infection Control Compliance**

    i. Implement ongoing review to ensure that nursing facilities are complying with best practice infection control standards.

    ii. Engage in bi-directional communication with Nursing facility Association through reporting of state audits and identify issues, revise audits, training, or policy as needed.

    iii. Use data analytics to measure and respond to facility infection control performance

    iv. Analyze infection control practices against outcomes to identify effective interventions to inform infection control education.

    Examples in Massachusetts: MSCA/HSL Infection Control Command Center met three times a week with state officials to identify and address infection control issues and used data to identify impactful infection control interventions.

CHALLENGE III: Personal Protective Equipment (PPE)

***Challenge III*: PPE:** Expand the supply of personal protective equipment to mitigate infection of nursing facility staff and residents (Figure 4).

Overview: Historically, nursing facilities do not use large amounts of personal protective equipment (PPE). However, the infectious nature of COVID-19 has led to a sharp increase in PPE usage, helping to push the global supply chain for PPE to the limits, and leading to shortages of and long lead times for PPE. Individual nursing facilities are typically 120-bed facilities that have especially low purchasing power for PPE, and many suppliers require minimum order sizes of tens of thousands of units. In addition, new and changing government infection control guidelines on PPE usage have challenged nursing facility operators' ability to predict the amount of the PPE they require. State and nursing facility association leaders together have the ability to help nursing facilities conduct scenario and sensitivity analyses to better predict PPE needs, gain access to timely PPE supply, and match scarce resources to facilities most in need.

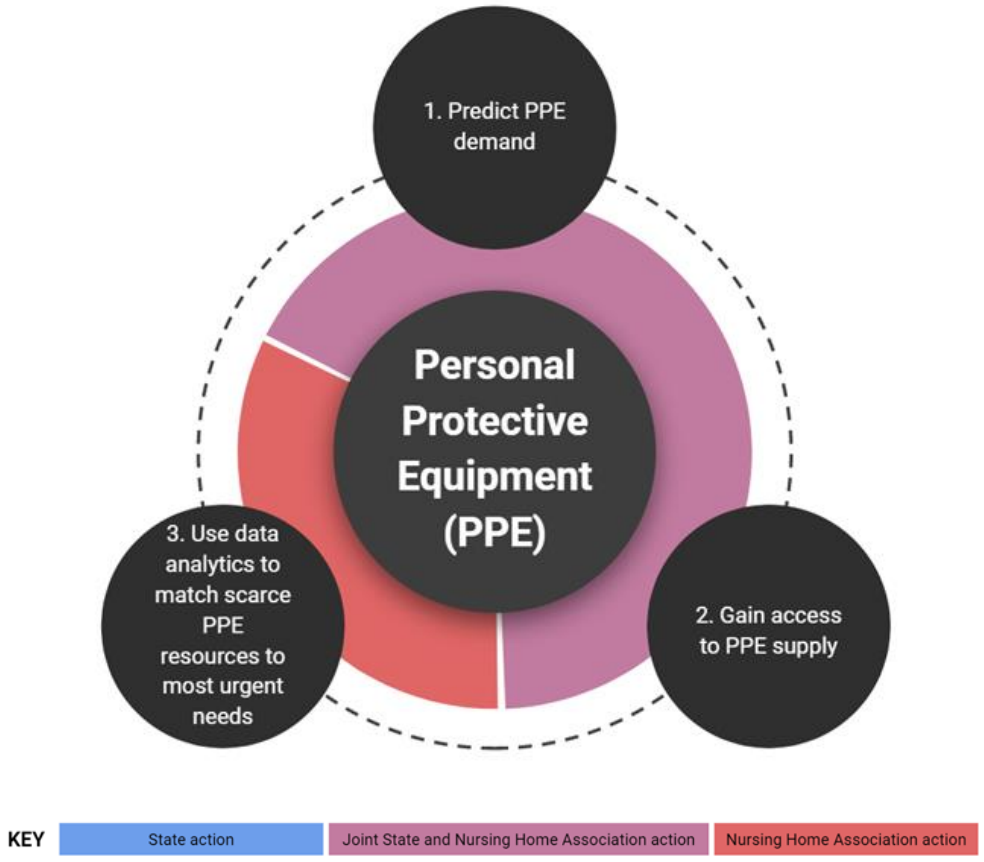

Figure 4: State and Nursing facility Association actions to address PPE challenges.

Objective: Expand the supply of personal protective equipment to mitigate infection of nursing facility staff and residents.

To achieve this goal, states and nursing facility associations should support the following initiatives:

1. **Assist nursing facilities with burn rate calculations to predict PPE** to reflect new and increased PPE burn-through rates and align nursing facilities on PPE usage best practices:

    i. Provide clear and consistent guidance for the utilization and conservation of PPE that aligns with federal requirements. This guidance should address PPE best practices in COVID-positive, COVID-negative and COVID-presumptive units. The goal of this guidance is to eliminate ambiguity and align PPE best practices across nursing facilities.

    ii. Introduce a network-level PPE burn-through calculator to gain visibility into aggregate shortages. *Example: In Massachusetts, Mass Senior Care partnered with the MIT-based COVID-19 Policy Alliance to build a PPE demand calculator incorporating PPE usage best practices and taking into account reported PPE inventory and infection rates. Outputs aggregated the predicted number of facilities that would be short and by what quantity.*

    iii. Introduce a PPE burn-through calculator for intuitive and uniform facility-level PPE demand prediction. *Example: In Massachusetts, Mass Senior Care partnered with the MIT-based COVID-19 Policy Alliance to build a facility-facing calculator to help individual nursing facilities project 6-week PPE consumption so they can adequately plan for procurement. These projections are based on weekly data reported by facilities. The tool was shared with the 300+ nursing facilities in the state and is used to inform quantities and cadence of PPE orders placed by nursing facilities.*

    iv. Aggregate PPE demand across nursing facilities to increase the purchasing power of these organizations. Many suppliers require minimum order sizes of thousands of units per PPE type, far beyond what any individual nursing facility requires or can finance. PPE demand aggregation enables nursing facilities to meet minimum order quantities. Furthermore, this aggregation helps decrease the bidding power gap between nursing facilities and hospitals. *Example: In Massachusetts, Mass Senior Care partnered with the MIT-based COVID-19 Policy Alliance to aggregate demand PPE volumes across nursing facility networks, allowing nursing facilities to piggyback on a larger state order and procure $1.2 million of PPE.*

2. **Secure Reliable PPE supply**

   i. Create statewide PPE Exchanges for the purpose of aggregating orders. States can also enable nursing facilities to order PPE without meeting minimum order quantities by facilitating the execution of these transactions and the last mile delivery of the PPE.

   ii. Identify non-traditional domestic sources of certified PPE with timely product availability that could fulfill either aggregate or individual nursing facility orders.

   iii. Work with state and federal agencies to secure government funding source for PPE.

   iv. Establish a stockpile of PPE including N95 masks, surgical masks, isolation gowns, face shields and gloves to help nursing facilities address high-priority, short-term needs.

   v. Help facilities diversify PPE supplier network. *Example: In Massachusetts, Mass Senior Care contacted both traditional PPE suppliers (e.g. McKesson) and alternative, Massachusetts-based suppliers like Merrow Manufacturing in Fall River to explore PPE procurement options with the potential for faster turnaround times.*

   vi. Appoint a designated person responsible for PPE procurement to research and vet PPE, negotiate PPE pricing, facilitate PPE orders for statewide nursing facilities, manage supplier relationships, and address last-mile delivery logistics. *Example: In Massachusetts, Mass Senior Care appointed a designated person responsible for PPE procurement, and this helped facilitate the placing of two large orders for MA-based nursing facility facilities between March-May, 2020 totaling more than $3,000,000.*

3. **Use data analytics to match scare PPE resources to most urgent needs**

   i. Introduce a network-level PPE burn-through calculator to identify facilities most in need. *Example: In Massachusetts, Mass Senior Care partnered with the MIT-based COVID-19 Policy Alliance to build a PPE demand calculator that identified facilities that would likely be short of PPE and by what quantity. Mass Senior Care's Infection Control Command Center communicated upcoming expected shortages to relevant facilities.*

   ii. Prioritize facilities with largest shortages for donations and fast-turnaround PPE orders, including the State stockpile, by using a network-level PPE burn-through calculator. These resources could bridge the need until the next PPE order arrives.

   iii. Explore options for PPE reallocation within facility networks to alleviate short-term shortages. While there wily be resistance to sharing PPE across long-term care networks, it is recommended that nursing facilities pool resources to the highest degree possible as a means to address high needs in the short term.

4. **Educate facility managers and staff on PPE best practices to ensure proper use of PPE**

   i. Review the role of the PPE Coach and how to incorporate this role in process surveillance.

ii. Present current regulatory guidance on PPE optimization and proper donning and doffing of PPE. *Example: Multifacility organization shared helpful PPE implementation tips as well as visual demonstrations.*

iii. Support non-clinical staff by providing education on the importance of PPE use and the cleaning and disinfecting process within facilities.

CHALLENGE IV: Workforce

***Challenge IV*: Workforce:** Expand and better prepare nursing facility workforce to manage ongoing operations and surge (Figure 5).

Overview: Nursing facility staffing challenges were at a crisis point prior to the COVID-19 outbreak, due primarily to the inability to pay a competitive wage, which is linked to government funding. In Massachusetts alone there were an estimated 5,600 vacant direct care nursing positions (RNs, LPNs, and CNAs) pre-COVOID-19. The COVID-19 outbreak has exacerbated that problem, with a new disruptive factor estimated at an additional 20% of existing staff who are now not able to or not coming to work due to exposure or fear of exposure to the virus. Taken together these pre-and post-COVID-19 conditions now produce an estimated 30% staff vacancy rate. State and nursing facility association leaders together have the ability to help nursing facilities retain existing workers, recruit new workers, and build and allocate a pool of emergency workers to manage surge.

Figure 5: State and Nursing facility Association actions to address workforce challenges.

Objective: Expand nursing facility workforce to manage both ongoing operations and surge.

1. **Retain existing workers for ongoing operations.**

   i. Support competitive wages to frontline nursing facility workers. Wages for frontline RCAs, CNAs, and nurses should be comparable to wages for frontline workers elsewhere in healthcare (e.g. hospitals), retail, and services sectors. *Example: In Massachusetts, the state offered $1,000 signing bonuses to new workers applying via the LTC State Portal and the Monster.com portal.*

   ii. Support temporary childcare and housing arrangements for workers to reduce risk of infection transmission at home. *Example: In Massachusetts, the state negotiated with state hotel operators to provide reduced rates for housing of healthcare workers involved in COVID-19 response. In addition, The Department of Early Education and Care (EEC) established Exempt Emergency Childcare Programs to serve vulnerable children and the children of families who are required to work to maintain the health, safety and welfare of all of the commonwealth's citizens.*

   iii. Help facilities convey appreciation and respect to employees. *Example: In Massachusetts, the Mass Senior Care produced a short, 2-minute-long video conveying appreciation to current employees for their tireless and critical work, especially during times of crisis. The video was translated to Haitian Creole and Spanish, and it was circulated among all employees in the 300+ nursing facilities in the state.*

   iv. Encourage facilities to use temporary, targeted compensation interventions and offer competitive wages. Facilities may be more willing to introduce temporary compensation interventions rather than changes to hourly wages because of facility owner concerns that: hourly pay at onset comes with long term pay expectations, increasing wages for new employees would create a discrepancy in pay between new and existing staff, increasing wages for CNAs or CNA aides would lead to pressure for increasing wages for RNs and LPNs as well, and recruitment bonuses could incentivize existing employees to leave current employers to join new ones. *Example: In Massachusetts, facilities successfully hired CNAs during the surge by introducing overtime pay, temporary hero pay for working in COVID-positive units, and higher pay for hard-to-fill shifts.*

2. **Recruit new workers for ongoing operations.**

   i. Introduce a permanent, non-certified, entry-level position such as Resident Care Assistant (RCA) to increase applicant pool and support existing staff. Unlike the traditional nursing facility care roles, the RCA position can attract applicants with little to no previous experience or existing certification. Making this role more accessible to a larger applicant pool and a faster rate of ramp up for new employees. *Example: Massachusetts has introduced a non-certified, entry-level RCA position. Responsibilities of the entry-level role include indirect and direct care to residents and to help support Certified Nursing Assistant (CNA).*

ii. Endorse and provide a supporting infrastructure for this new role. This includes providing clarification on how RCA responsibilities fit into existing guidance and statutes at the State and Federal levels, how facilities should document RCA skills competencies, as well as operationalizing the RCA role with State surveyor staff, ensuring this role is included in their staffing evaluation process during their 9-15 month facility survey.

iii. Include entry-level position in workforce metrics to promote the adoption of these roles by facilities. Support including RCA hours in payroll-based journal (PBJ) staffing reporting as part of CMS star ratings. *Example: In Massachusetts the state approved the inclusion of entry-level RCA hours in the clinical HPPD (hours per patient per day) metric, which was introduced to assess staffing shortages during the COVID-19 pandemic.*

iv. Provide regulatory support for the entry-level position by noting in writing that the State will refrain from taking disciplinary action against facilities that hire and delegate responsibilities to RCAs, provided that the responsibilities conform to the job description released by the State.

v. Match candidates to facilities by building public-private partnerships with labor market platforms. *Example: Massachusetts built a state portal to recruit RNs, LPNs, CNAs, and RCAs and match them to facilities.*

vi. Provide financial support for centralized candidate screening, onboarding, and retention oversight by nursing facility associations. This financial support would be applied to advertising for RCA positions, maintaining a job portal, conducting pre-screening for facilities, implementing RCA onboarding processes, and following up with candidates a few weeks post onboarding to provide additional support and ensure successful integration into the nursing facility.

vii. Support facilities in implementing asynchronous, online training for CNA certification. Help facilities to apply for and implement hybrid nurse aide training programs onsite in their facilities or in partnership with approved training organizations. Provide financial support to Nursing facility Organizations to provide help with online training applications. *Example: Massachusetts approved online, asynchronous training along with clinical training and competency assessment at one facility to allow RCAs to become certified as CNAs. This training program allowed for upskilling via online, asynchronous courses, enabled RCAs to satisfy their practical experience requirements while working, and removed the financial burden of the training from the applicant. A path to certification served as a "golden ticket" for recruiting workers with no prior nursing facility experience who would not have otherwise considered careers in this sector.*

viii. Expedite CNA test scheduling and results reporting. Support scheduling certification tests within 1 week of request and provide results to both candidate and sponsoring facility electronically within 24 hours.

ix. Engage in community outreach to increase applicant pool and help facilities understand and support the top concerns of applicants. *Example: In Massachusetts, Mass Senior Care partnered with the MIT-based COVID-19 Policy Alliance to engage with the Boston Haitian*

community, a primary source of nursing facility workers. They conducted focus groups and identified compensation, safety, and career progression as top applicant concerns.

x. Help facilities onboard RCAs. *Example: In Massachusetts, Mass Senior Care partnered with the MIT-based COVID-19 Policy Alliance to create an onboarding toolkit of best practices for onboarding RCAs.*

xi. Increase applicant pool by seeking in-house certification for entry-level workers. *Example: In Massachusetts, nursing facilities implemented online, asynchronous training along with clinical training and competency assessment to allow RCAs to become certified as CNAs.*

xii. Match candidates to facilities by building public-private partnerships with labor market platforms. *Example: In Massachusetts, Mass Senior Care partnered with the MIT-based COVID-19 Policy Alliance and Monster.com to advertise openings for the RCA position. The Mass Senior Care -Monster.com platform allowed Mass Senior Care to streamline the process of advertising role openings across the 300+ MA nursing facilities.*

xiii. Address breakdowns in platform marketplace by providing communications toolkit to facilities, vetting applicants, and providing a warm handoff to facilities. *Example*: While the Mass Senior Care-Monster.com platform enabled Mass Senior Care to easily reach a large pool of applicants, Mass Senior Care learned that actual hiring initially required a warm, *human* hand-off of applicants to facilities. Mass Senior Care worked with the MIT-based COVID-19 Policy Alliance to provide proof-of-concept to facilities regarding the value of RCAs. They assembled a team of volunteers with no prior HR experience to own the last-mile logistics of the recruitment process. This team screened applicants to confirm their commitment, confirmed the nursing facility's intention to recruit, and performed applicant-facility matches.

3. **Build and allocate a pool of emergency workers for surge.**

   i. States can support provider by adding clinical rapid response teams and National Guard logistical support.

   ii. Expand access to and provide housing for out-of-state licensed health care providers. *Example: Massachusetts nursing facilities arranged and paid for hotel accommodations to house frontline staff who needed temporary housing while caring for COVID-19 residents.*

   iii. Credential veterans, retired physicians, and foreign trained providers. Allow providers to obtain emergency reinstatement of their licenses without completing the typically required credits of continuing medical education.

   iv. Use data analytics to match scarce workforce resources to most urgent needs. *Example: Mass Senior Care collaborated with the MIT-based COVID-19 Policy Alliance to identify facilities with low staffing to prioritize matching of RCA applicants. The group also analyzed geographical locations with large applicant pools to prioritize RCA placement efforts.*

4. **Secure government funding source to pay a competitive and premium wage**
   i. Adjust Medicaid reimbursement rates to reflect competitive and premium wages for frontline nursing facility workers. Since over 2 out of 3 residents rely on Medicaid to pay for their care, a nursing facility's ability to increase wages is directly tied to government funding. 70% of a nursing facility's budget is spent on staff wages and benefits. *Example: In Massachusetts, during the height of the COVID-19 pandemic, the Baker Administration and Executive Office of Health and Human Services provided up to $130 million in Accountability and Support funding for nursing facilities to respond to the COVID-19 pandemic. Nursing facilities spent these investments on workforce, PPE and infection control.*

   ii. Competitive wage is critical to recruiting new workers. In order to recruit and retain new workers to the long term care sector, wages must be increased and remain competitive. *Example: In a focus group with community leaders and potential workers, one of the biggest barriers to working in skilled nursing facilities is inadequate pay, especially during the pandemic when potential workers perceived a job in health care to be unsafe or hazardous.*

5. **Educate workforce on infection control and PPE best practices**
   i. Provide educational webinars to nursing facility staff on PPE guidance and proper use. *Example: Mass Senior Care provided weekly webinars to clinical staff and non-clinical staff working in long term care facilities. Training included the proper use of PPE and the role of the PPE Coach.*

   ii. Provide up-to-date information on PPE guidance. *Example: Mass Senior Care sent daily COVID-19 memos to nursing facility members on the latest guidance regarding PPE from CDC, DPH and CMS. Mass Senior Care staff was a resource to members who needed clarification.*

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