WHAT'S NEEDED FOR TRANSFORMATIONAL NURSING HOME REFORM TO IMPROVE QUALITY AND OVERSIGHT

- **Guarantee of evidence-based safe staffing essential for quality and safety.**

  Nursing home residents, their families, and advocates already know what research confirms - there is a direct relationship between sufficient staffing and quality care in order to achieve the best possible quality of life for residents**.** Insufficient nursing staff negatively impacts all residents in a nursing home and undermines the dignity of both residents and staff. Numerous studies of nursing homes reveal a strong positive relationship between the number of nursing home staff who provide direct care to residents on a daily basis and the quality of care and quality of life of residents. The dangers of understaffing have been common knowledge in the U.S. nursing home industry since the 1980s and culminated with the findings from the 2001 study of Appropriateness of Minimum Nurse Staffing Ratios published by Centers for Medicare & Medicaid Services (CMS).[1] [2]

  The 2001 CMS landmark staffing report identified specific minimum staffing thresholds below which quality of care would be compromised. It recommended a daily minimum standard of 4.1 hours of total direct care nursing time per resident: 2.8 hours certified nursing assistants; 0.75 hours RNs; and 0.55 hours licensed practical/vocational nurses. Research conducted for the report found that staffing levels falling below this minimum put nursing home residents at risk.[3]

  It's also important to note that 4.1 HPRD does not take into account quality of life and dignity issues which are important components of the nursing home requirements and rightful expectations for residents and their families. 4.1 HPRD represents a clinical standard. This standard would undoubtedly be much higher if the higher acuity levels existing 20+ years after the CMS study were considered[4]

[1] Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Report to Congress: Phase II Final Volume 1 Contract # 500-0062/TO#3, Prepared for Centers for Medicare and Medicaid Services, Prepared by Abt Associates Inc. Cambridge, MA, December 24, https://theconsumervoice.org/uploads/files/issues/CMS-Staffing-Study-Phase-II.pdf

[2] Appropriate Nurse Staffing Levels for U.S. Nursing Homes (sagepub.com)

[3] State Nursing Home Staffing Standards Summary Report (theconsumervoice.org)

[4] Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Report to Congress, Op.Cit., page 11: "...Although the Phase II analysis did not identify different staffing levels that maximized quality for different case mix groupings, it did find that adverse outcomes were significantly higher at the same

and all services truly required were provided --- all services including person-centered care and dignity.

However, state staffing requirements, with a few exceptions, are nowhere near the 4.1 HPRD recommended level. Despite what is known about the relationship between staffing levels and quality care, staffing standards in almost every state remain severely low. Residents have waited decades for safe staffing around the clock. Every day that passes without sufficient staffing jeopardizes their health, safety and welfare.[5]

Massachusetts staffing requirements also fall short. Regulation 150 CMR 007 (B) (2) (d) states: "Sufficient nursing personnel to meet resident nursing care needs based on acuity, resident assessments, care plans, census and other relevant factors as determined by the facility. On and after April 1, 2021, sufficient staffing must include a minimum number of hours of care per resident per day (PPD) of 3.58 hours, of which 0.508 hours must be care provided to each resident by a registered nurse. The facility must provide adequate nursing care to meet the needs of each resident, which may necessitate staffing that exceeds the minimum required PPD".[6] A minimum nursing care ratio of 3.58 PPD is substantially below the CMS recommended minimum of 4.1 PPD, for safe resident care.

Dignity Alliance Massachusetts, together with other advocates, assert that too many Massachusetts nursing homes operate below the Commonwealth's insufficient minimum regulatory limits, thereby putting residents in great jeopardy and failing to protect the dignity of both residents and staff. As of Q3, '22, the most recent available data, 75% of MA nursing homes operate below an average of 3.58 HPRD.[7]

According to National Consumer Voice for Quality Long Term Care, "The enforcement of a minimum staffing standard would not only protect nursing home residents it would address the long-standing job quality problems that plague nursing homes. On average, nursing home staff turnover is 52% each year, which is the result of low-wages, poor benefits, inadequate training, and little opportunity for job growth. The burden of providing essential and critical care falls largely on women, a majority of whom are women of color, while they are treated poorly by nursing home owners and operators." [8]

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staffing levels for facilities of higher case mix. The investigators concluded that higher staffing levels are warranted for facilities with residents of higher acuity and functional limitations..."

[5] State Nursing Home Staffing Standards Summary Report (theconsumervoice.org)

[6] https://www.mass.gov/doc/105-cmr-150-standards-for-long-term-care-facilities.

[7] Long-Term Care Community Coalition compilation of Q3, '22 database of *CMS payroll-based journal data*, located at https://nursinghome411.org/data/staffing/staffing-q3-2022/. Total Direct Care Staff combines hours from RNs, LPNs, and nurse aides (CNAs and NA in Training) directly involved in resident care and excludes Admin Director of Nursing (DON), RN Admin & RN DON.

[8] https://theconsumervoice.org/news/detail/news_list/podcast-episodes-on-inadequate-staffing.

Massachusetts elected and appointed leaders have a responsibility to enforce existing regulations and to support expected new staffing requirements Such efforts are not only good public policy, but also good politics. "According to a recent poll, 80% of U.S. registered voters supported candidates who support requiring minimum staffing standards in nursing homes. Eighty-nine percent of Democrats and 74% of Republicans said they were more likely to vote for candidates who backed minimum staffing standards." The poll conducted by Fabrizio Ward and Impact Research and released by AARP also found wide support for candidates who back proposals that support family caregivers and help seniors live in their own homes. [9]

Even though Massachusetts has an inadequate staffing ratio, there needs to be enforcement and a penalty, such as a freeze on new admissions. for failure to maintain a safe ratio.

- **Any requirement for nursing homes to report staffing on evenings, weekends, and holidays.**

A truly transformational provision relative to staffing would be to require nursing homes to publicly report on their web site and to the Center of Health Information and Analysis their direct care staffing levels for night and weekend levels, as well as overall levels.

Medicare's payroll records for nursing homes showed that on weekends, there were **11 percent fewer nurses providing direct care and 8 percent fewer aides**. Staffing levels fluctuated substantially during the week as well, when an aide at a typical home might have to care for as few as nine residents or as many as 14.

It was determined in 2018 that most nursing homes had fewer nurses and caretaking staff than they had reported to the government for years, according to federal data, bolstering the long-held suspicions of many families that staffing levels were often inadequate. The records for the first time reveal frequent and significant fluctuations in day-to-day staffing, with particularly large shortfalls on weekends. On the worst staffed days at an average facility, the data show, on-duty personnel cared for nearly twice as many residents as they did when the staffing roster was fullest. The data, analyzed by Kaiser Health News, come from daily payroll records Medicare only recently began gathering and publishing from more than 14,000 nursing homes, as required by the Affordable Care Act of 2010.

[9] https://press.aarp.org/2023-05-05-New-AARP-Poll-Majority-of-Voters-Want-More-Support-for-Family-Caregivers .

Medicare previously had been rating each facility's staffing levels based on the homes' own unverified reports, making it possible to game the system.[10]

- **Strong provisions for oversight of nursing home finances, transparency, and accountability.**

  1. "Owner" of nursing homes is defined (SECTION 3, line 91-93, page 5) anyone having ownership interest of 5% or more. The definition drops some of the language in this item that was included in H. 648. The 5% rule is the current standards in DPH regulations.

     We suggest wording such as: "Any organization that operates, conducts, owns, manages, or maintains one or more skilled nursing facilities (SNF) or nursing homes shall prepare annual consolidated financial statements of related entities, and submit visual representations of their organization structure. Entities with ownership or control interests of any amount. Said reports shall include names and addresses of any owner, and shall, in the case, the owner is, or includes, an LLC, partnership, private equity, real estate investment trust (REIT), venture capital, or other entity."

  In definition of Owner in line 62, and line 474 or wherever reference to ownership interest appears, **we suggest deleting ownership interest of any amount and inserting in place thereof "any ownership interest**".

  Background: *The New York Attorney General Investigation of nursing home financial fraud and self-dealing that led to severe understaffing and resident neglect and harm revealed fraudulent activity by one (1) percent owners.[11] It also should be noted that in May 2019[12] as a safeguard against corrupt applicants, Kansas revised its licensure application requirements to include review of <u>any</u> percentage of ownership the applicant had or has in the operations or the real property of a nursing home. This tightening of application requirements was due*

[10] 'It's Almost Like a Ghost Town.' Most Nursing Homes Overstated Staffing for Years - The New York Times (nytimes.com), 7/8/18

[11] Attorney General James Sues Long Island Nursing Home for Years of Fraud and Resident Neglect | New York State Attorney General (ny.gov). 12/26/22

[12] http://www.kslegislature.org/li_2020/b2019_20/measures/documents/sb15_enrolled.pdf
Page 19, Sec. 27. K.S.A. 2018 Supp. 39-927 is hereby amended to read as follows: 39-927. (a) An application for a license to operate an adult care home shall be made in writing to the licensing agency upon forms provided by it the licensing agency and shall be in such form and shall contain such information as the licensing agency shall require, which may include if applicable: "...(1) A detailed projected budget for the first 12 months of operation, prepared in accordance with generally accepted accounting principles and certified by the principal officer of the applicant, accompanied by evidence of access to a sufficient amount of working capital required to operate the adult care home in accordance with the budget, in the form of cash on deposit, a line of credit, applicant's equity, or any combination thereof; (2) a list of each current or previously licensed facility in Kansas or any other state, territory or country or the District of Columbia in which the applicant has or previously had any percentage of ownership in the operations or the real property of the facility; and..."

to the devastating impact from the bankruptcy closure of 15 Kansas nursing homes owned by Skyline.

MA residents also suffered from the bankruptcy closure of 5 Skyline nursing homes. And prior to Skyline, to fend off creditors and repeated fines for resident deaths and injuries, Synergy was forced to close 2 MA nursing homes and sell its other 9 properties by a court-ordered receiver. Synergy facilities were licensed to care for about 1,200 residents.[13]

We know the pain and suffering that can be caused by unscrupulous owners and management. The above examples highlight the need to vet all potential owners and decision-makers to protect nursing home residents. The additional time it would take to vet all acquiring or managing a nursing home is well worth the benefit of eliminating the pain, fear, and suffering to a nursing home resident from devious or incompetent owners and managers.

2. In the definition of "Person," Dignity Alliance recommended at the April 10 hearing, in addition to the list currently defining "Person", we strongly recommend including "LLC" and "other entity".

Background: LLCs and other entities (e.g. private equity, REITs, venture capital) are commonplace now. Including "other entity" also provides leeway for other future financial inventions.

3. In the language regarding transfer of ownership (SECTION 3, lines 118 -127), Dignity Alliance believes that in addition to the "current staff of the facility" and the "labor organization that represents the facility's workforce", also provide "notice of intent to acquire" to the following parties (same parties as 153.023 Voluntary Closure):

(a) Each resident of the facility and where applicable the resident's legal representative; (b) The designated family member of each resident; (c) The facility's resident council; (d) The facility's family council; (e) The Office of the State Long-term Care Ombudsman; (f) The Office of the Local Long-term Care Ombudsman; (g) The members of the General Court who represent the city or town where the facility is located; and (h) A representative of the local officials of the city or town where the facility is located.

Background: *To amplify the voice of nursing home residents, we recommend adding "a 501(c)(3) statewide advocacy organization that is comprised of individuals and organizations dedicated to the needs of older adults, people*

[13] https://www.bostonglobe.com/business/2018/11/02/synergy-health-centers-closing-nursing-homes-amid-mounting-bills-patient-injuries-and-deaths/m5PQV4d5WV4bLZ47902rNN/story.html.

with disabilities and their caregivers, and the transformation of long-term care". Furthermore, we recommend including the parties noted above [as well as the described 501(c)(3) organization] in notifications of <u>all</u> facility transactions addressed in 105 CMR 153.000 Licensure Procedure and Suitability Requirements for Long-Term Care Facilities. Here is a sample of such additional transactions:

153.007: Intent to Establish a Long-Term Care Facility - Other Licensing Requirements: Opportunity for Public Comment;
153.022: Transfer of Ownership, Opportunity for Public Comment and copy of notice of intent.

4. The report required in Section 9, of H3929 needs the following language to ensure that the financial reports are accurate and complete, and prepared in accordance with the provisions of the Financial Accounting Standards Board.

Suggested language would be:
Section 72 of chapter 111 of the General Laws, as most recently appearing in the 2020 Official Edition, is hereby amended, by inserting after said section 72, the following: -

Section 72 ½. Financial Transparency and Consolidated Financial Report.(a) (1) Commencing with fiscal years ending December 31, 2025, an organization that operates, conducts, owns, manages, or maintains a nursing home or facilities licensed pursuant to 105 CMR 153.000 *Licensure procedure and suitability requirements for long-term care facilities* shall prepare and file with the Center for Health Information and Analysis (CHIA)], at the times as the office [CHIA or the MassHealth Agency] shall require, an annual consolidated financial report.
(2) The annual consolidated financial report required to be prepared pursuant to paragraph (1) shall be reviewed by a certified public accountant in accordance with generally accepted accounting principles and with the Financial Accounting Standards Board's financial reporting requirements, with financial statements prepared using the accrual basis. If the organization has prepared an audit by a certified public accountant of its annual consolidated financial report for any reason, that audit shall be filed with CHIA, and, in that instance, no review of the consolidated financial report shall be necessary. The reviewed or audited report, as applicable, shall, in addition to the requirements set forth in 101CMR 206.000 *Standard Payments to Nursing Facilities* include, but not be limited to, the following statements:
(A) A balance sheet detailing the assets, liabilities, and net worth at the end of its fiscal year.
(B) A statement of income, expenses, and operating surplus or deficit for the annual fiscal period, and a statement of ancillary utilization and patient census.
(C) A statement detailing patient revenue by payer, including, but not limited to, Medicare, MassHealth, and other payers, and revenue center.
(D) A statement of cashflows, including, but not limited to, ongoing and new capital expenditures and depreciation.

(E) A combined financial statement that includes all entities reported in the consolidated financial report, unless the organization is prohibited from including a combined financial statement in a consolidated financial report pursuant to a state or federal law or regulation or a national accounting standard. When applicable, the organization must disclose to the office the applicable state or federal law or regulation or national accounting standard.
(3) In addition to the consolidated financial report, the following information shall be provided to the office as an attachment to the consolidated financial report:
(A) The financial information required by paragraph (2) of subdivision (a) from all operating entities, license holders, and related parties in which the organization has any ownership or control interest and that provides any service, facility, or supply to the skilled nursing facility.
(B) A detailed document outlining a visual representation of the organization's structure that includes both of the following:
(i) All related parties in which the organization has any ownership or control interest and that provides any service, facility, or supply to the skilled nursing facility.
(ii) Unrelated parties that provide services, facilities, or supplies to the skilled nursing facility or facilities that are operated, conducted, owned, managed, or maintained by the organization, including, but not limited to, management companies and property companies, and that are paid more than two hundred thousand dollars ($200,000) by the skilled nursing facility.
(b) The office shall post reports and related documents submitted pursuant to this section to its internet website.
(c) Any report, document, statement, writing or any other type of record received, owned, used, or retained by the office in connection with this section is a public record within the meaning of section 7, clause 26 of chapter 4 of the Massachusetts General Laws (MGL) and is subject to disclosure pursuant to the Massachusetts Public Records Act, section 10, chapter 66 MGL.
(d) The office shall develop policies and procedures to outline the format of information to be submitted pursuant to this section. The office shall determine if the information submitted pursuant to subdivision (a) is complete, but shall not be required to determine its accuracy.
(e) For the purposes of this section, "related party" means a home offices; management organizations; owners of real estate; entities that provide staffing, therapy, pharmaceutical, marketing, administrative management, consulting, and insurance services; providers of supplies and equipment; financial advisors and consultants; banking and financial entities; any and all parent companies, holding companies, and sister organizations; and any entity in which an immediate family member of an owner of those organizations has any ownership interest. "Immediate family member" includes spouse, natural parent, child, sibling, adopted child, adoptive parent, stepparent, stepchild, stepsister, stepbrother, father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, daughter-in-law, grandparent, and grandchild.
(f) This section shall not apply to an organization that has no related parties as defined in subdivision (e), except that the organization is required to submit a detailed document outlining a visual representation of the organization's structure

as set forth in subparagraph (B) of paragraph (3) of subdivision (a). Nothing in this section shall be construed to require a government entity license holder, that is not a related party, to file a consolidated financial report for a nursing home management company that operates under its license.
(g) Consistent with the reports and requirements required for subdivisions (a) to (e), all information submitted pursuant to this section shall be accompanied by a report certification signed by a duly authorized official of the health facility or of the health facility's home office that certifies that, to the best of the official's knowledge and information, each statement and amount in the accompanying report is believed to be true and correct.[i]

- **Meaningful provisions to require a living wage to attract and retain direct care staff.**

  Nursing home staff shortages and high turnover rates among staff are largely attributed to low wages. While Medicare and Medicaid reimbursement rates to nursing homes can indirectly influence worker wages, states also can adopt policies to require or incentivize providers to raise wages paid to direct care workers, according to the Kaiser Family Foundation.[14]

  H.648, (Section 10, lines 447 -466) included provisions requiring a living wage. Why was this dropped from H.3929? Dignity Alliance believes that wages and benefits, especially of nursing and nursing assistants, need to be at a competitive level in view of the significant responsibilities of caring for some of our most vulnerable citizens. We support efforts to raise the wage to at least $25.00, possibly with an inflation factor. If this, or any other legislation or budget, were to be implemented there must be an independent audit of any public funds that may be provided to support the higher wage, and there must be provisions that prevent any such funds from being calculated in profits or excess of income over expenses.

- **Provisions to address the use of temporary staffing which increases cost, fails to provide quality, and causes morale issues that impact retention and turnover.**

  It's no secret that temporary staffing agencies have been both a boon and bane for the nursing home industry, providing necessary but very costly labor during the pandemic. Staffing problems have persisted long enough in the post-Covid era to warrant their use, but pricing practices have led to an outcry and push for state regulation.

[14] State Actions to Address Nursing Home Staffing During COVID-19, MaryBeth Musumeci , Emma Childress , and Belle Harris, 5/16/22, https://www.kff.org/medicaid/issue-brief/state-actions-to-address-nursing-home-staffing-during-covid-19/.

Use of travel nurses has become associated with declining quality of care, training headaches and high turnover. In order to reduce the use of such nurses hired through temp agencies, many states have been engaged in legislative efforts. Over the last two years, a growing number of states have begun to request or implement regulations that will curb price gouging on employee salaries, ban conversion fees when hiring a temp employee and restrict non-compete clauses that geographically limit an employee's ability to get hired permanently. Some states also have plans underway to create a registry for filing complaints related to temp agencies, while others are pushing to provide operators with visibility into staffing agency payment rates.[15]

- **Provisions to address the abuse of anti-psychotic drug use by nursing homes.**

  H.3929 is missing an important opportunity to protect residents from being prescribed and treated with antipsychotic medications, unless they were clinically indicated and systematically evaluated for an individual resident's needs. Although unwarranted antipsychotic use in nursing homes in some states has declined, Massachusetts is not among them, according to data released in April 2022. Given staff shortages, staff are likely to medicate residents to lessen the frequent demands for hot meals or timely toileting.

  There are important questions to ask the attending physician, staff nurses or facility administrator: What medications are you using to treat my family member with dementia? With antipsychotic medications, why are they being used and what benefits do you expect them to have? Could other health issues, like a urinary tract infection, be causing confusion or aggressive behaviors? Are non-pharmacologic approaches appropriate?

- **Updated requirements for nursing homes to include sufficient social workers to provide interventions around behavior, mental health and relationships with resident, families, and staff by requiring at least one full-time social worker for every sixty residents,**

  The interventions by social workers around behavior, mental health and relationships (with residents, families, and staff) are crucial to the progress of residents. It is not unusual that those issues will impact the physical health of residents. The current regulations about social work services were developed in the 1970s. That makes no sense today and allows nursing home admins/CEOs to say they are following the regulations when things go wrong. It also permits DPH to survey facilities using outdated regulations. In those days facilities were much

[15] **Efforts to Rein In Nursing Home Temp Agencies Gain Ground After 'Price Gouging,' Other Troubling Practices,** Zahida Siddiqi, 6/14/23, https://skillednursingnews.com/2023/06/efforts-to-rein-in-nursing-home-temp-agencies-gain-ground-after-price-gouging-other-troubling-practices/.

smaller and there were no special care units (SCUs). Social workers and others should be available to respond to what has been a changing landscape in this industry - especially if we want to provide for a better quality of life and care for residents. NASW in Connecticut tried to update their regulations and failed each time. When they inserted more up to date proposals in a nursing home reform bill their proposals passed and were implemented. Most Social Workers – especially those working in nursing homes – are dealing with serious understaffing; their jobs are difficult, sometimes traumatic, and undercompensated. A properly trained and compassionate Social Worker can make a huge difference in residents' lives. For example, at one nursing home western MA which has a low rating, one Social Worker has been integral in helping folks with housing applications to get people back into the community, and has been great at collaborating with Independent Living Centers.

- **Improvement in the Personal Needs Allowance despite inflation.**

  The Personal Needs Allowance of $72.80 per month hasn't been increased in 30 years. If it had been indexed to inflation, it should be around $160 per month today. A comprehensive nursing home reform bill should include a long-sought upgrade. In Massachusetts and across the U.S., hundreds of thousands of nursing home residents are locked in a wretched bind: Driven into poverty, forced to hand over all income and left to live on a stipend as low as $30 a month.

  In a long-term care system that subjects some of society's frailest to daily indignities, Medicaid's personal needs allowance, as the stipend is called, is among the most ubiquitous, yet least known.

  Nearly two-thirds of American nursing home residents have their care paid for by Medicaid and, in exchange, all Social Security, pension and other income they would receive is instead rerouted to go toward their bill. The personal needs allowance is meant to pay for anything not provided by the nursing home, from a phone to clothes and shoes to a birthday present for a grandchild.

- **Improvement in resident privacy and quality.**

  While H.3929 does move to an explicit authorization for small home model nursing facilities, (lines 333 -353), there also must be a requirement that all new construction or substantial reconstruction shall follow this model. Furthermore, to improve privacy and infection control, all nursing homes must move to not more than two residents per room with a provision any shared room shall require the affirmative approval of both residents.

- **Requirement to reserve a bed hold for medical or non-medical leave of absence by MassHealth nursing home residents.**

In House 648, section 9 (lines 439 – 444) there are provisions for MassHealth to reimburse nursing homes for residents on medical leave of absence (up to 20 days) or non-medical leave of absence (up to 10 days), however, this was deleted from H.3929. Each year, in the general appropriations bill, this provision has to be included in the budget, but it should be established as a matter of right, and the provisions in H.648, section 9, should be restored in H.3929. The language is currently under consideration in the FY '24 Conference Committee.

- **Requirement to publish the names of nursing home medical directors and require certification.**

A critically important step toward dramatically improving transparency and accountability for seniors and their families and the health systems that serve them is publishing medical director names and certification. That essential information has often been secret and elusive, especially during the pandemic, according to Suzanne Gillespie, MD, president of the AMDA, the Society for Post-Acute and Long Term Care Medicine.

There are many reasons why the public needs to know the name of the medical point person in these facilities, since this person's job, as required by CMS, is essential to assuring that staff members have credentials, know proper transfer protocols, prepare for disasters, and understand the specific needs of highly vulnerable geriatric patients.

The public needs to know the physician in charge competently performs peer review, like making sure that the patients' own physicians are providing appropriate care, and that employees have appropriate competencies, like knowing what to do if there's a Valium shortage. Patients and their families also would then be able to learn how thinly spread the director's tasks might be. Gillespie said she has heard of a medical director who oversaw 16 separate nursing home buildings in different locations, all at the same time.

Other reasons for publishing names of medical directors include being able to see provider qualifications, said AMDA's immediate past president Karl Steinberg, MD, a San Diego-based medical director of two nursing homes and chief medical officer of two nursing home service corporations whose facilities each have their own medical directors. He has heard of nursing homes hiring an interventional radiologist, a retired surgeon, and a pediatrician as their medical directors, despite those individuals having no training in geriatrics, long-term care medicine, end-of-life care, or the complex regulatory framework under which nursing homes must operate.[16]

[16] Nursing Home Medical Directors Should Be Named Publicly, Bill Urges | MedPage Today, 9/21/22.

We endorse S.389, An Act providing for the certification of medical directors in skilled nursing facilities, which is currently before the Committee on Elder Affairs.

- **Requirement that each nursing home have an established and audited capital improvements fund that must be sufficient to provide major maintenance of facilities.**

  The majority of nursing home buildings are institutional in feel and the care is not directed by the residents. New evidence is emerging that larger nursing homes were less effective at protecting residents from COVID-19 during the pandemic. [17] The time is ripe to reimagine what a nursing home could be in a post-pandemic world.

  The goal should be to fund and support nursing homes with well-compensated staff providing resident-directed care in a small-home setting. As the name implies, small-home settings provide housing and care for groups of older adults in a more home-like, less institutional setting. Small-home models like the Green House model have been found to provide higher quality care relative to traditional nursing homes.

- **Requirements under "temporary or provisional" license to a nursing home.**

  H.3929 (lines 247 – 250) provides for DPH ability to offer a temporary or provisional license for up to one year "to prevent undue hardship on the applicant or licensee." What about undue hardship on residents or staff of the nursing home. There should be protections included and a compliance officer appointed.

Additional proposals that would further enhance transformational legislation are found in Dignity Alliance testimony to the Committee on Elder Affairs regarding H. 648.

[i] https://www.natlawreview.com/article/what-price-transparency-california-sb-650-shines-light-skilled-nursing-facility.

[17] Grabowski, D.C. The future of long-term care requires investment in both facility- and home-based services. *Nat Aging* **1**, 10–11 (2021). https://doi.org/10.1038/s43587-020-00018-y.