Nursing Homes & COVID-19:

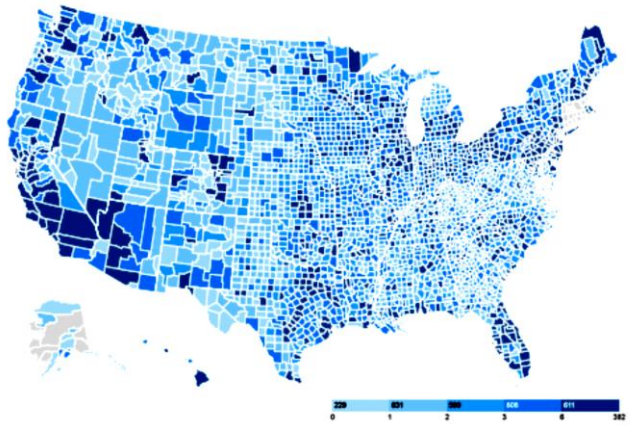
Mitigating the Spread of the Virus through Federal Guidance and Technology

NATIONAL ASSOCIATION of COUNTIES NACo®

Counties & Nursing Homes

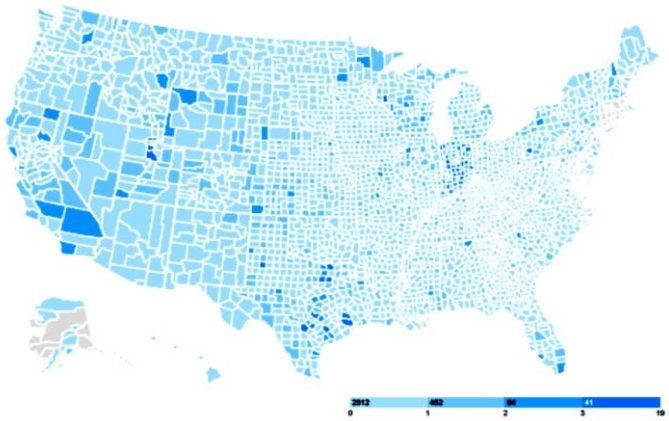
- Counties own and operate **449** nursing homes, and directly support **758** nursing homes and skilled nursing facilities
- **85 percent** of states with county governments have at least one county-owned or county supported nursing home
- **Thirty percent** of county nursing homes are not-for-profit and could require significant funding to contain the virus.

Number of Nursing Homes Across the U.S.



Source: NACo Analysis of U.S. Department of Health & Human Services Data

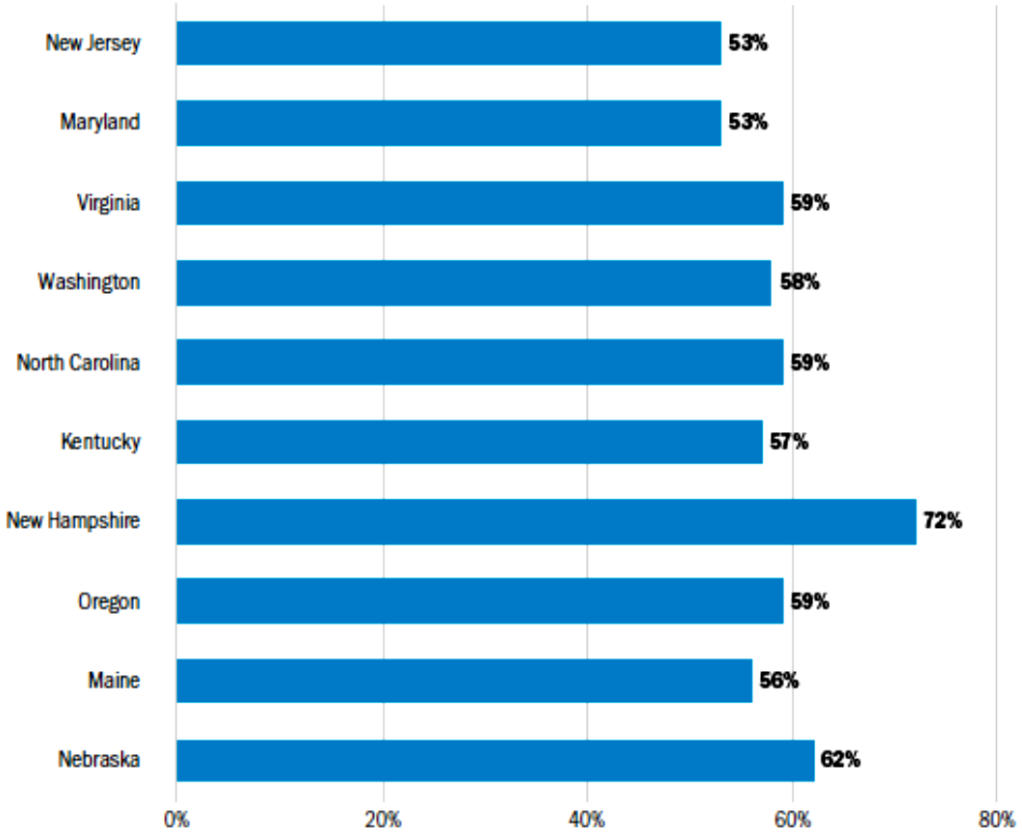
County Supported Nursing Homes



Source: : NACo Analysis of U.S. Department of Health & Human Services Data

COVID-19 Impact on Nursing Homes

LONG-TERM CARE FACILITY DEATHS AS A SHARE OF TOTAL STATE DEATHS



Of the 43 states reporting, 10 states have deaths in long-term care facilities that account for **over 50% of the state's total COVID-19 death count.**

NACo BRIEF

NURSING HOMES & COVID-19

JUNE 2020

Today's Speakers:

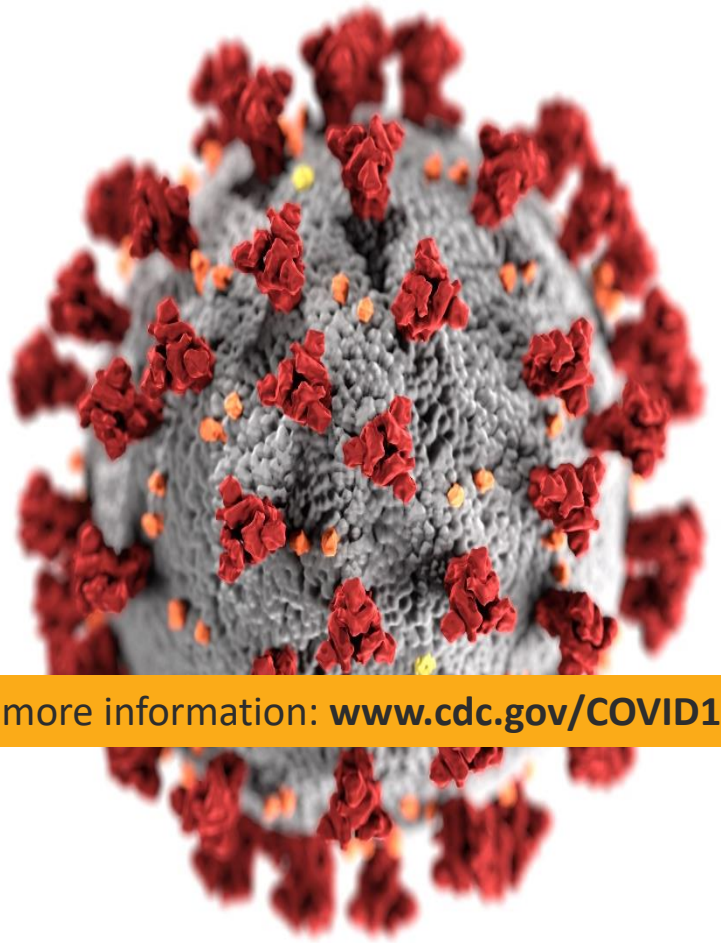
Kara Jacobs Slifka
Medical Officer,
Centers for Disease Control and Prevention (CDC)

Diane Flynn
Vice President of Strategy and Institutional Products, OptumHealth

Kevin Evans
Executive Director,
Martha T. Berry Medical Care Facility

Preventing the spread of SARS-CoV-2 in Long-term Care Settings

Kara M. Jacobs Slifka, MD, MPH
COVID-19 Response
Centers for Disease Control and Prevention



For more information: **www.cdc.gov/COVID19**

Key Strategies

- Keep COVID-19 Out: Prevent SARS-CoV-2 from entering (or re-entering) long-term care facilities
- Identify Infections early: monitor and test
- Prevent transmission: implementing aggressive infection prevention and control practices

Assign One or More Individuals with Training in Infection Control to Provide On-Site Management of the Infection Prevention and Control (IPC) Program.

- This should be a full-time role for at least one person in facilities that have more than 100 residents or that provide on-site ventilator or hemodialysis services.
- Smaller facilities should consider staffing the IPC program based on the resident population and facility service needs identified in the facility risk assessment.
- CDC has created an online training course that can be used to orient individuals to this role in nursing homes (https://www.train.org/cdctrain/training_plan/3814)

Report COVID-19 case, facility staffing, and supply information to NHSN weekly

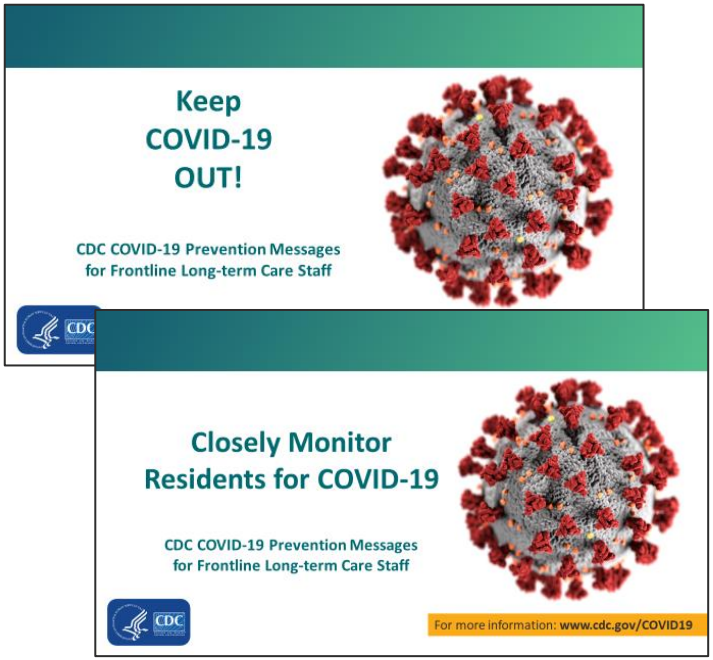
- CDC's National Healthcare Safety Network (NHSN) provides long-term care facilities with a customized system to track infections and prevention process measures in a systematic way. Nursing homes can report into the four pathways of the LTCF COVID-19 Module including:
  - Resident impact and facility capacity
  - Staff and personnel impact
  - Supplies and personal protective equipment
  - Ventilator capacity and supplies
- Weekly data submission to NHSN will meet the CMS COVID-19 reporting requirements

Educate Residents, HCP, and Visitors about COVID-19

- Provide information about COVID-19 and strategies for managing stress and anxiety
- Regularly review CDC guidance for current information and ensure staff and residents are updated when guidance changes.
- Educate residents and families:
  - Actions the facility is taking to protect them and/or their loved ones
  - Any visitor restrictions that are in place
  - Actions residents and families should take to protect themselves in the facility, emphasizing the importance of hand hygiene and source control.

Educate Healthcare Personnel

- Educate and train HCP, including facility-based and consultant personnel (e.g., wound care, podiatry, barber) and volunteers who provide care or services in the facility.
- Emphasize:
  - Hand hygiene
  - Source control
  - Cleaning and disinfecting the environment
  - Selection and use of personal protective equipment (PPE)
  - Not working when ill



https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

Communicate with HCP, Residents, and Family

- Have a plan and mechanism to regularly communicate with residents, families and HCP, including if cases of COVID-19 are identified among residents or HCP.

TECHNOLOGY for more frequent video chats, emails, text messages, and phone calls.

We are teaching residents to use video chat applications (such as Skype and FaceTime) and will help read emails or texts on personal devices if needed.

CARDS AND LETTERS with messages of support and updates on family members.

We are supplying paper, pens, envelopes and postage for residents to easily reply. If needed, we will write replies dictated by residents.

RECORDED VIDEO MESSAGES to share via email or text message, if live-video chatting is not feasible.

We will help record outgoing messages and share incoming messages with residents.

"VISITS" through a glass window or a parade of cars.

We will make every effort to ensure residents are able to safely participate if scheduled in advance.

VISUALS TO EXPRESS CARE. For example, ribbons around trees or benches, planting flowers outside, or outdoor posters and banners to show support.

We will work to designate areas to place these visuals and safely take residents outside to show them these symbols of your support.

CARE PACKAGES that could include items such as photographs, cards, drawings, snacks, and entertainment (such as books, magazines, and puzzles).

We will establish a system for care package drop-offs that is safe and does not require entry into the facility.

DEDICATIONS on the in-house cable channel and intercom system.

We can 'dedicate' songs or share anecdotes via the intercom prior to broadcasting a movie or playing music. If your loved one has a favorite song, poem, movie or television show, please let us know.

We encourage you to share additional ideas and creative ways we can work together to support our residents.

Implement Source Control Measures

- HCP should wear a facemask at all times while they are in the facility.
  - **Cloth face coverings should NOT be worn by HCP instead of a respirator or facemask if PPE is required.**
- Residents should wear a cloth face covering or facemask (if tolerated) whenever they leave their room, including for procedures outside the facility.
- Visitors, if permitted into the facility, should wear a cloth face covering while in the facility.

Implement Visitor Restrictions

- Restrict all visitation to their facilities except for certain compassionate care reasons, such as end-of-life situations.
  - Communicate with residents and families; use alternative visitation methods
  - Post signs at the entrances to the facility and screen visitors
- Considerations for visitation when restrictions are being relaxed include:
  - Permit visitation only during select hours and limit the number of visitors per resident (e.g., no more than 2 visitors at one time).
  - Schedule visitation in advance to enable continued social distancing.
  - Restrict visitation to the resident's room or another designated location at the facility (e.g., outside).

Testing in Nursing Homes

- Testing conducted at nursing homes should be implemented *in addition to* recommended IPC measures.
- Facilities should have a plan for testing residents and HCP for SARS-CoV-2.
- Testing practices should aim for rapid turnaround times (e.g., less than 48 hours) in order to facilitate effective interventions.
- Testing the same individual more than once in a 24-hour period is not recommended.
- Antibody (serologic) test results should generally not be used as the sole basis to diagnose an active SARS-CoV-2 infection and should not be used to inform IPC action.

General Nursing Home Testing Recommendations

- HCP
  - Perform initial viral testing of all HCP, along with weekly viral testing thereafter, as part of the recommended reopening process
  - State and local officials may adjust recommendation based on prevalence in the community
  - HCP who test positive for SARS-CoV-2 should be excluded from work until they meet return to work criteria.
- Residents
  - Perform initial viral testing of each resident in a nursing home, as part of the recommended reopening process
  - Perform viral testing of any residents who have signs or symptoms of COVID-19

Nursing Home Testing during Outbreaks

- A single case of COVID-19 is considered to be an outbreak
- Perform expanded viral testing of **all** residents and HCP in the nursing home if there is an outbreak in the facility
- After initially performing viral testing of all residents and HCP in response to a new case, CDC recommends repeat testing to ensure there are no new infections among residents and HCP, and that transmission has been terminated.
- Repeat testing should be coordinated with the local, territorial, or State health department.

Evaluate and Manage Healthcare Personnel

- Implement sick leave policies that are non-punitive, flexible, and support HCP to stay home when ill.
- Ask HCP to regularly monitor themselves for fever and symptoms consistent with COVID-19.
  - Remind HCP to stay home when they are ill.
  - If HCP develop fever (T≥100.0ºF) or symptoms consistent with COVID-19 while at work they leave the workplace.
  - HCP with suspected COVID-19 should be prioritized for testing.
- Screen all HCP at the beginning of their shift for fever and symptoms of COVID-19.

Provide Supplies Necessary to Adhere to Recommended IPC Practices

- Hand Hygiene Supplies: alcohol-based hand sanitizer with 60-95% alcohol inside and outside every resident room, other resident care and common areas. *Unless hands are visibly soiled, an alcohol-based hand sanitizer is preferred over soap and water in most clinical situations.
- Personal Protective Equipment (PPE): Perform and maintain an inventory of PPE in the facility and report PPE shortages.
    - Make necessary PPE available in areas where resident care is provided and implement optimization strategies
- Implement a respiratory protection program
- Use an EPA-registered disinfectant from List N on the EPA website

Identify Space in the Facility that Could be Dedicated to Monitor and Care for Residents with COVID-19

- This could be a dedicated floor, unit, or wing in the facility
- Identify HCP who will be assigned to work only on the COVID-19 care unit when it is in use.
  - HCP should have access to restrooms and a break area
- Have a plan for how residents will be transferred to this unit
  - HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. **Cloth face coverings are not considered PPE and should only be worn by HCP for source control, not when PPE is indicated.**

Create a Plan for Managing New Admission and Readmissions Whose COVID-19 Status is Unknown

- Depending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or a separate observation area so the resident can be monitored.
- HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents.
- Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission.

Evaluate Residents with Symptoms of COVID-19

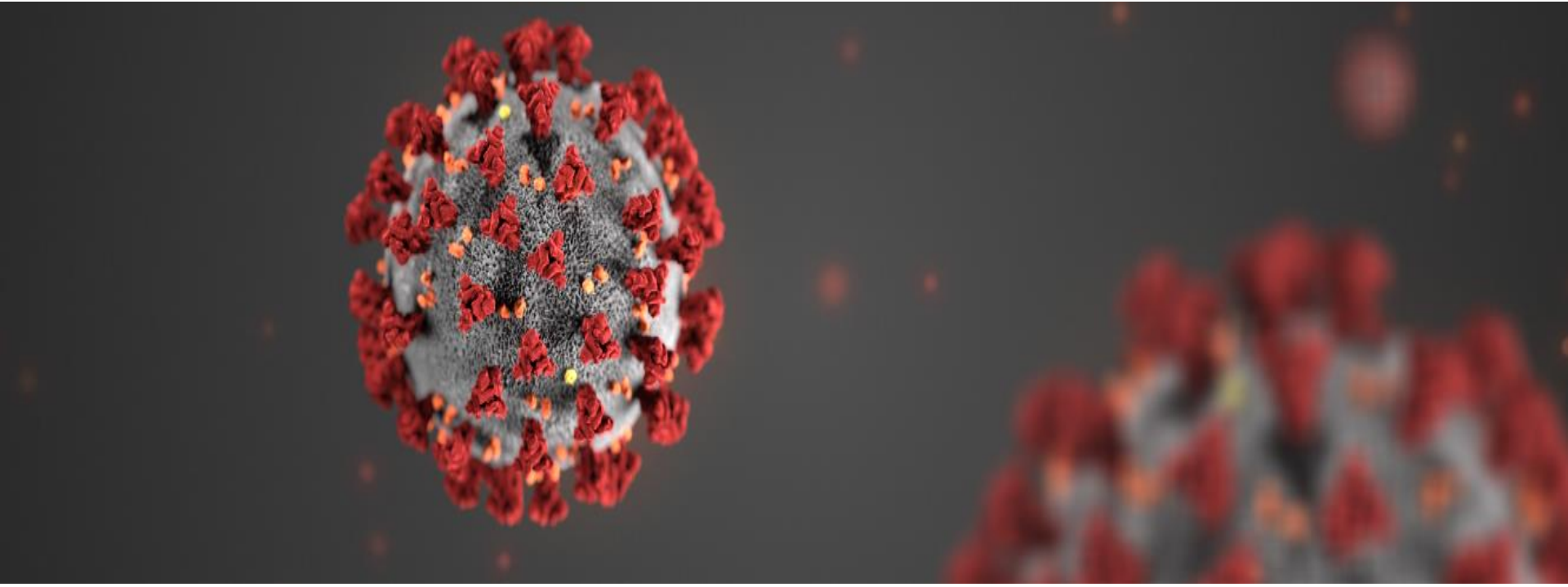
- Ask residents to report if they feel feverish or have symptoms consistent with COVID-19.
- Actively monitor all residents upon admission and at least daily for fever (T≥100.0°F) and symptoms consistent with COVID-19.
  - Older adults with COVID-19 may not show common symptoms. Additionally, more than two temperatures >99.0°F might also be a sign of fever in this population.
- The health department should be notified about residents or HCP with suspected or confirmed COVID-19, residents with severe respiratory infection resulting in hospitalization or death, or ≥ 3 residents or HCP with new-onset respiratory symptoms within 72 hours of each other.

Manage Residents with Symptoms of COVID-19

- Residents with suspected COVID-19 should be prioritized for testing.
- Residents with known or suspected COVID-19 should ideally be placed in a private room with their own bathroom.
  - Residents with known or suspected COVID-19 should be cared for using all recommended PPE.
  - Increase monitoring of ill residents, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least 3 times daily to identify and quickly manage serious infection.
- Universal use of all recommended PPE on affected unit should be used

Implement Social Distancing Measures

- Cancel communal dining and group activities
- Remind residents to practice social distancing, wear a cloth face covering (if tolerated), and perform hand hygiene.
- Remind HCP to practice social distancing and wear a facemask (for source control) when in break rooms or common areas.
- Considerations when restrictions are being relaxed include:
  - Allowing communal dining and group activities for residents without COVID-19, including those who have fully recovered while maintaining social distancing, source control measures, and limiting the numbers of residents who participate.



The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

Thank you!

Timeline of Federal Regulatory Actions

Feb/March 2020

- CMS Guidance on PPE and Infection Control

April 2020

- New COVID-19 Case Reporting Requirements
- Formation of Nursing Home Commission

May/June 2020

- Release of new toolkit for states

Federal Resources for Nursing Homes

Omnibus Packages:

- ✓ **Families First Coronavirus Response Act** (P.L. 116-127)
- ✓ **Coronavirus Aid, Relief, and Economic Security (CARES)** Act (P.L.116-136)
- ✓ **Paycheck Protection Program and Health Care Enhancement Act** (P.L. 116-139)

Standalone Bills:

- ✓ **HEROES Act** (H.R. 6800)
- ✓ **Quality Care for Nursing Home Residents and Workers During COVID-19 Act** (H.R. 668/S.3644)
- ✓ **Nursing Home COVID-19 Protection and Prevention Act** (H.R. 6972/S.3768)

Federal Advocacy Messages

1. Increase federal funding for testing in skilled nursing facilities and long-term care facilities.

2. Support legislation that enhances federal aid for skilled nursing and long-term care facility COVID-19 response efforts.

Telehealth Use in Long Term Care Facilities

June 2020

OPTUM®

Agenda

- Evolution of Telehealth
- Historical Telehealth Pilots
- COVID Impact
- What’s Ahead

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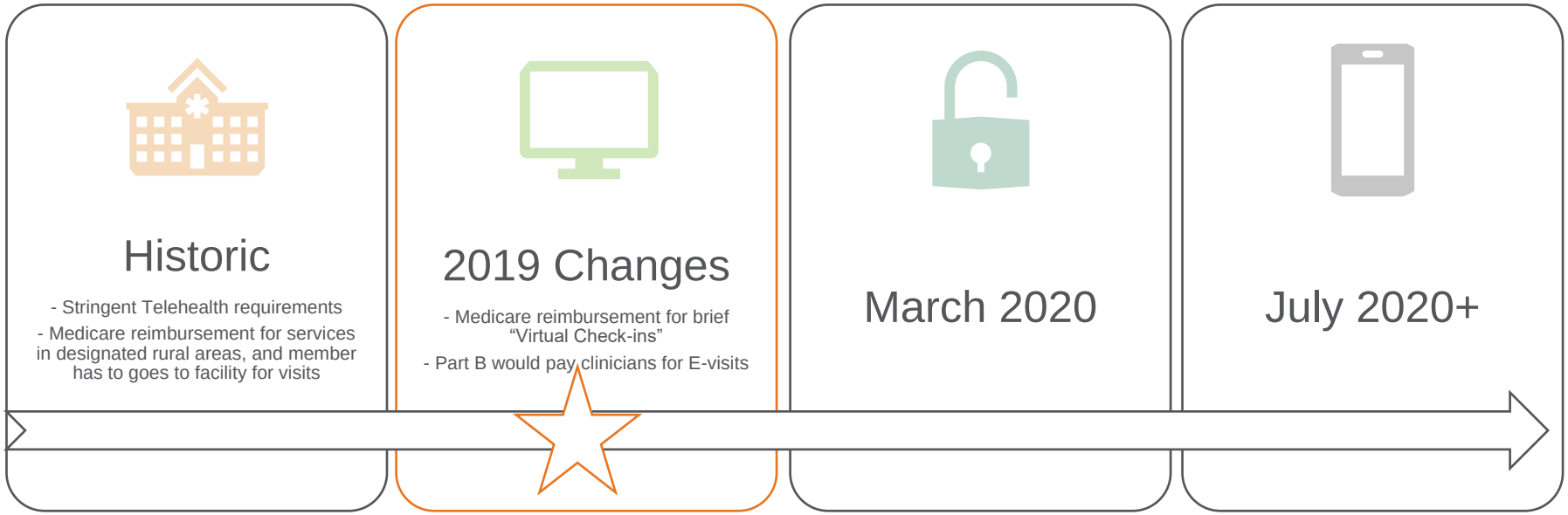
Evolution of Telehealth



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Historical Telehealth Pilots

Use Case

Replace telephonic interactions

Use Case

Lower bypass rate by obtaining more consistent biometric information

Use Case

Reduce in-person visits

Pilot # 1	Pilot # 2	Pilot # 3	Pilot # 4	Pilot # 5
Pilot: Tested 2 separate vendor platforms to provide telehealth services. Utilized our providers and directed the Skilled Nursing Facility (SNF) on specific instances to use a telehealth visit.		**Pilot**: Sticker that was placed on post acute members to gather biometric information.	**Pilot:** Vendor technology would utilize electronic medical records to search for common phrases and alert us on trending patterns.	**Pilot:** Robotic telehealth platform to conduct virtual visits with members.
Issue - Low SNF engagement		**Issues** - Consent needed - 5 day sticker life	**Issues** - Excess noise - Limited actionable alerts	**Issues** - Member confusion - Low SNF engagement

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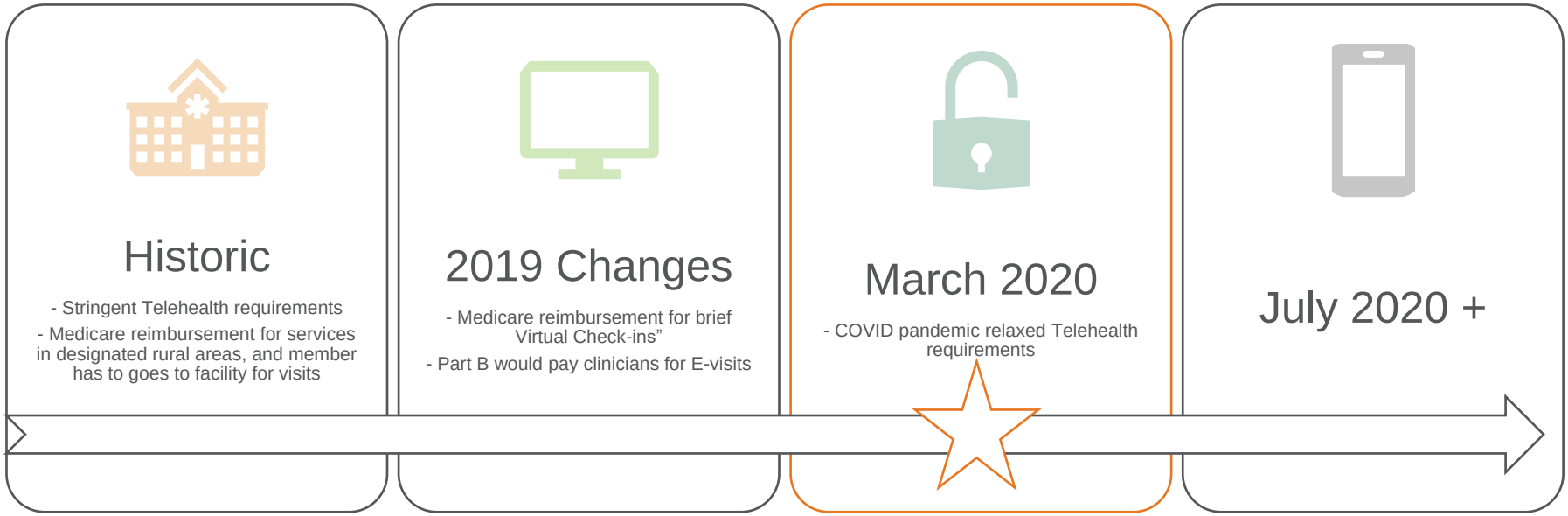
Evolution of Telehealth



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COVID Impact on Clinical Care

Telehealth Changes

- Expansion of Telehealth with 1135 Waiver
  - HHS Office for Civil Rights waived penalties who serve patients in good faith through the use of everyday communication technologies like FaceTime or Skype.
- Medicare to pay for visits conducted via Telehealth from a range of providers: doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers
- Telehealth visits can be conducted in all counties and all settings
- Medicare Telehealth visits are considered the same as in-person visits and paid at the same rate

COVID Challenges

- Limited PPE supply
- Limited staff allowed in facility

Optum's Response

- Utilized Telemedicine technology to conduct virtual patient and family visits
  - SNF telemedicine vendors
  - Zoom
  - Facetime
- Deployed iPads to SNF to facilitate visits

Outcomes

- Conducted just over 4000 visits from March 25th to today
- SNF bought in to telemedicine visits*

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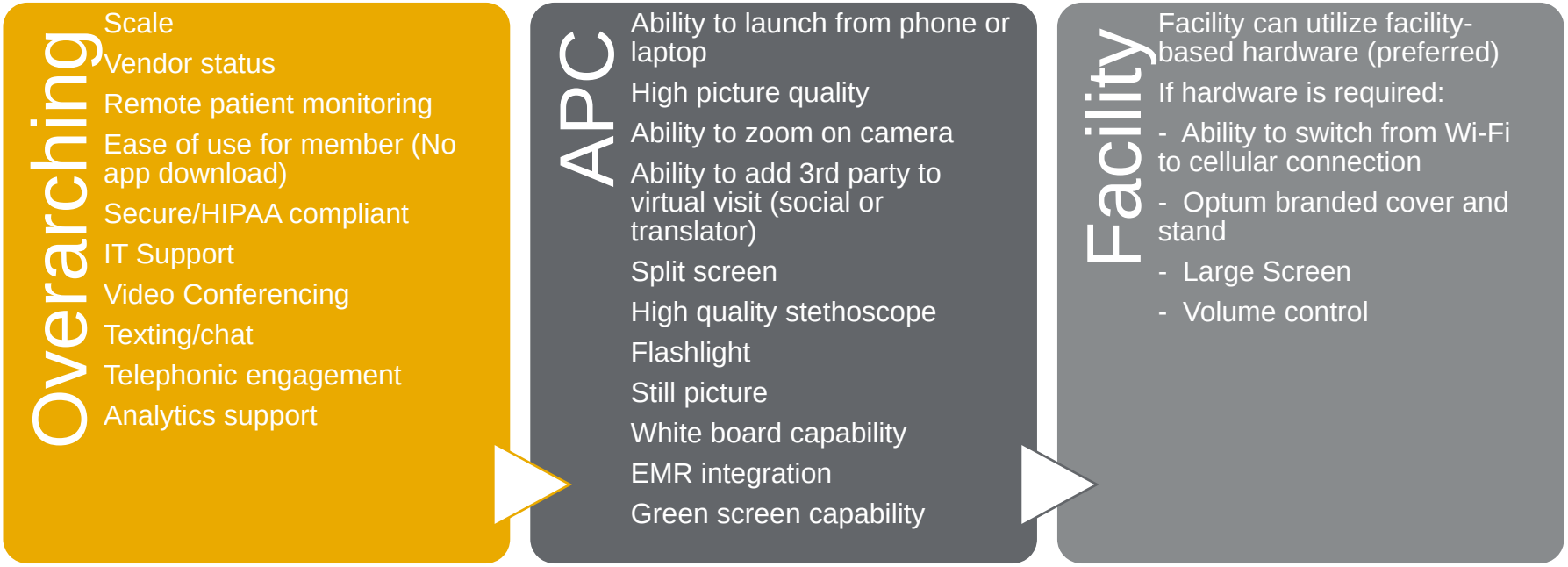
Requirements for Telehealth

What did we learn?



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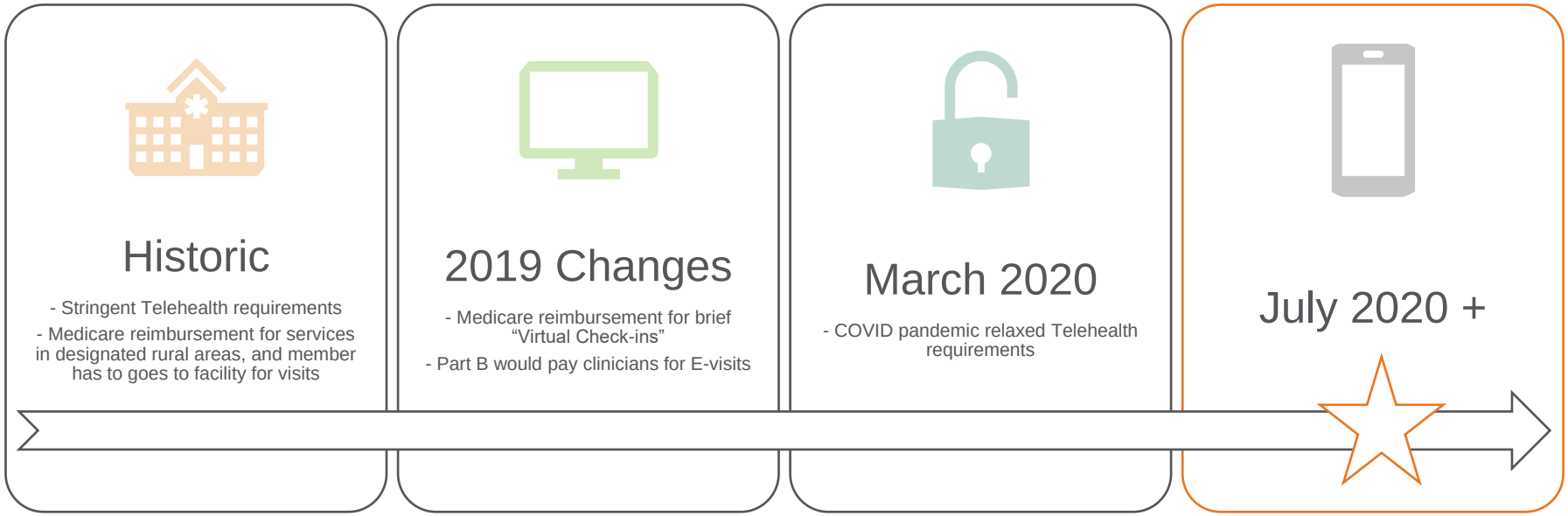
Evolution of Telehealth



What's Ahead?

How will we use Telemedicine in our future?

Remote Monitoring Pilot

Description: Ability to monitor respiratory rate, heart rate, skin temperature, and cough through a physician prescribed single-use medical device. This will allow Optum to independently deliver data that we were previously dependent on the facility to report.

Features:

- **FDA approved**
- **30 day battery**
- **Continuous vital sign monitoring**

Pandemic Emergency Plan 2020

Description: Implementing the capability to conduct telemedicine visits for any member in our footprint when an in-person visit isn't feasible.

Solution:

- **Works with any device**
- **Doesn't require app or software downloads.**
- **Secure and HIPAA compliant**

Updated Clinical Model 2021

Description: Expanding our core clinical model from being in-person focused to also include telemedicine visits and remote patient monitoring.

Components:

- **In-person visits**
- **Telemedicine visits**
- **Remote monitoring**

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How To Utilize Federal Regulations Inside A Pandemic

Kevin Evans, LNHA, CEA

Executive Director/Administrator
Martha T. Berry Medical Care Facility

Expert Witness - State of Michigan, 9 years

Instructor, NHA prep classes - ACHCA, 11 years

Goals To Discuss:

- When, why and how we started
- What resources we used to prepare for the pandemic
- What went well early
- What challenges we had to overcome
- Where we stand and ongoing challenges

Pandemic Historical Timeline Document Draft

https://www.dropbox.com/s/a887xpwfkrl08mq/Timeline%20Rough%20Draft%20v2%20003.pdf?dl=0

https://bit.ly/2AdulqY

Got Started Early/ Restarted Often

- Emergency Preparedness Guidelines S&C-14-12-ALL (2014)
  - Every emergency - checklist
- Emergency rule was posted Sept 8, 2016 and in effect November 15, 2017
- Tabletop drills
- Relationship building with the local Healthcare Coalition (R2N)
- New rules and checklists, facility risk assessment and facility assessment

Got Started Early/ The Big Restart

- Began – "what if" conversations
  - Comes to the US
  - Comes to the State
  - Comes to the County
  - Enters our building
- Emergency Preparedness began meeting weekly – QAPI and Infection Prevention Folded in
- First "test" case
- Began Isolation procedures
- Began working with vendor partners early, still wasn't enough due to being a low priority

Pandemic Planning Resources/Directions

- State Governor
- CDC
- CMS
- OSHA
- HHS (state and federal)
- NFPA/LSC
- Trade Associations
- Consultants

Resource Spreadsheet

https://www.dropbox.com/s/ofl32fmpoqfx1o0/Copy%20of%20MCMCFC%20COVID-19%20Resources%20062620.xlsx?dl=0

https://bit.ly/2Blhu6J

What Was Difficult

- How fast PPE dried up
- The Regional Emergency Coalition was not prepared – (no PPE in 6 warehouses)
- Local agencies didn't understand what was happening or the risk to our seniors
- Initial low priority, diverted PPE and tests
- Volume of information and direction coming from multiple departments

Difficult Is No Excuse

- 100/0
- Had to continually state: "I understand, but what can WE do to keep our residents and staff safe?"
- Use Influenza protocols/ droplet precautions
- Isolate upon notice of symptoms
- Expect all symptoms to equal COVID19

Early – What We Did

- Created an expandable isolation area, starting with eight and with plans for up to 107 and three distinct sections inside isolation – Positive, new and readmits, pending release
- Use Influenza protocols/ droplet precautions
- Isolate upon notice of symptoms
- Expect all symptoms to equal COVID19

Early – What We Did

- Decision to close the facility if a case touched our county
- Began being creative on PPE acquisition – aka "I got a guy…"
- Inventorying then securing PPE after finding "shrinkage"
- Ramped up FaceBook communications to families

What Went Well To Get Started

- Past drills prepared us for some of the impact
- Go Kits had N-95s in them
- Iterative thought process of "what ifs" prior to it hitting the state helped us move quickly through stages
  - Also helped the team to work from problems to solutions – more team elasticity
- Emergency, Quality, Risk and Infection Prevention all talking early
- Utilizing Flu protocols early

What Went Poorly Early

- Early call in's and theft due to staff fear
- Poor communication to staff on all of the new processes
- Not sharing levels of PPE or levels of COVID19 in the building early on
- Isolation hero's being treated poorly due to fear – taking sides and placing blame
- Not training staff how to manage a crisis
- Not training staff on how to prepare families for crisis, and duty of care
- Weekends were the worst

How We Overcame

- Aggressive in our ongoing approach to obtaining PPE
- Published our Employee Assistance Program hotline and actively recommended it to those who exhibited stress
- Administrator worked every weekend for eight weeks
- Set up texting program for staff and for family and residents for quick and easy communication

How We Overcame, Continued

- Aggressive in our ongoing approach to obtaining PPE
- Published our Employee Assistance Program hotline and actively recommended it to those who exhibited stress
- Administrator worked every weekend for eight weeks
- Set up texting program for staff and for family and residents for quick and easy communication

The Big Challenge – Test All

- After a third small wave, and multiple one's and twos, we tested all residents – seven asymptomatic – moved to isolation
- Two weeks no new symptoms – tested all staff mid May
  - Were not able to do so prior due to supply
  - Seventeen asymptomatic staff – no clusters, every shift, floor and department
- Delays in testing time got our results back the week before Memorial Day
- Decided to test all residents again on Memorial Day
- NO NEW RESIDENT POSITIVES!

Where We Stand Now

- One resident, who is on day 57 asymptomatic positive
- Last resident new positive, May 8, possibly from a family member who removed her PPE to kiss her
- State HHS requiring weekly testing of all staff until region is determined to be low risk
- Conventional capacity on PPE (except for foot covers)
- Census significantly lower and not bouncing back

Biggest Ongoing Challenges

- Fatigue for all staff
- Misconception/oversimplification by public
- Data collection requests changed over 20 times
- Each well meaning and hard working department, bureau, etc, not recognizing the context when they say "It should not be that hard…"
- No clear direction on visitation
- Refocusing audit and quality process checking to the whole facility and not just infection prevention
  - Made more challenging by the fear of the new survey process with fines and directed PoCs for any Infection Prevention violation

Big Takeaways

- The amazing number of heroes we get to work with every day
- Ongoing communication with multiple styles of media helps overcome fear
- Relationships formed before the crisis impacted our ability to succeed during the crisis
- Each department at every government level has people trying to do their best to help – it is still up to us to stay in front of care, as regulations and clarifications lag
- If we waited for new regulation, it would be too late to care
- We already know what to do, even if it is named a different name like COVID19

Questions?