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Keeping Nursing Home Residents Safe and Advancing Health in Light of COVID-19

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UNIVERSITY OF MICHIGAN

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Presentation Outline

1. Introduction
2. Key Findings and Recommendations Overview
3. Interim Hub Evaluation
4. Structural Approaches to Care for LTC Patients with COVID-19
5. Process Recommendations
6. Access to Mental Health, Visitation, and Other Health Care
7. Operational/Administrative Functions

Introduction

Objectives

- Evaluate the state's regional nursing home hub COVID-19 strategy, comparing Michigan's approach and outcomes to those in other states.
- Review national best practices for keeping nursing home residents as safe as possible and develop recommendations for preparedness in the event of another COVID-19 surge.
- Consider the continuum of long-term care services to minimize infections, morbidity, and mortality among individuals who require such services.

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Background

MI has 442 nursing homes

271 nursing homes had 1+ COVID-19 resident case(s)
209 of these nursing homes had 1+ COVID-19 resident death(s)

171 nursing homes had no COVID-19 cases among residents

112 nursing homes had only staff cases

61 nursing homes had neither staff nor resident cases

* 2020 COVID-19 cases and deaths through 8/19/2020; Source: Adjusted Michigan Department of Health and Human Services

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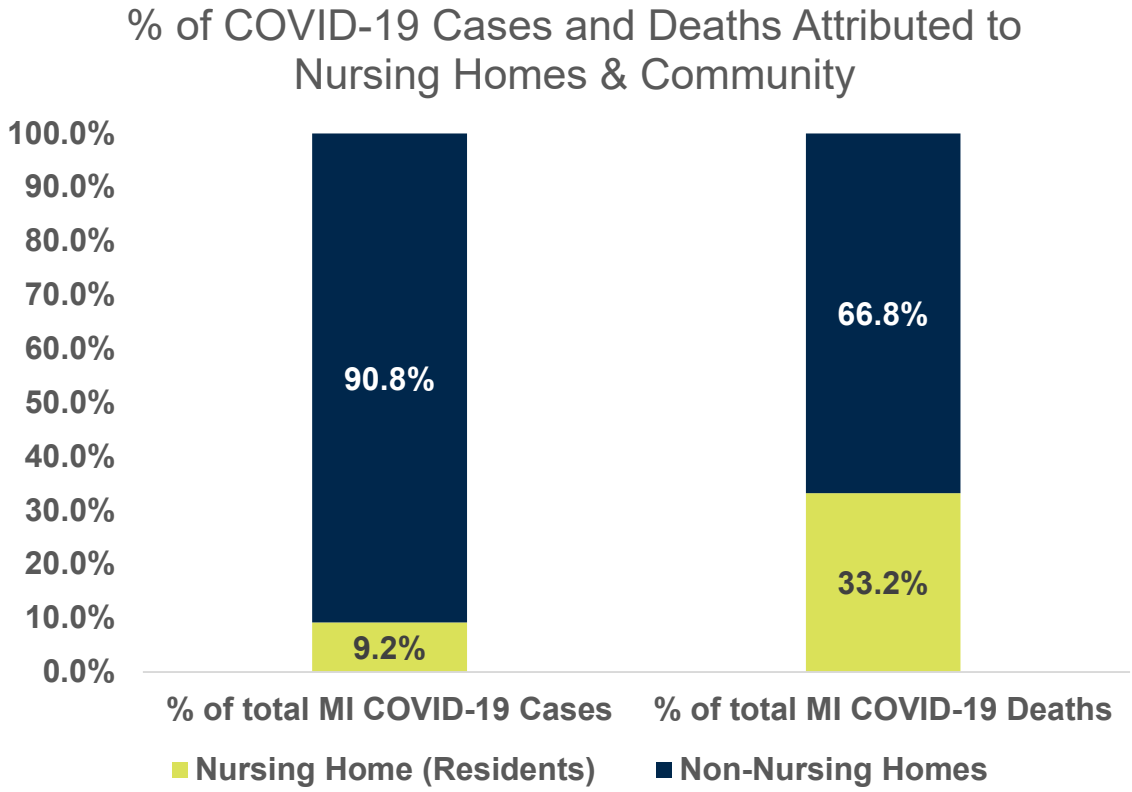
Background

State of Michigan*:
- **COVID-19 aggregate cases: 92,450**
- **COVID-19 aggregate deaths: 6,317**

Nursing Home Residents*:
- **COVID-19 cases: 8,546**
- **COVID-19 deaths: 2,100**

Nursing Home Staff*:
- **COVID-19 cases: 4,226**
- **COVID-19 deaths: 21**



* 2020 COVID-19 cases and deaths through 8/19/2020; Source: Adjusted Michigan Department of Health and Human Services

Michigan's COVID-19 Response: Key Policies for Long-term Care

March 14, 2020

Emergency Order (EO) issued, restricting visitation in nursing homes

April 15, 2020

Regional hubs established, EO restricts communal dining, enhances transfer and discharge procedures, requires reporting on PPE and COVID-19 cases in nursing homes

June 15, 2020

New requirements regarding admission and readmissions, telemedicine expansion

June 26, 2020

Followed up 6/30/20

MI Nursing Homes COVID-19 Preparedness Task Force established, safety measures extended, and visitation exceptions

Our Process

- Key informant interviews to identify best practices, challenges, and lessons learned
  - National policy experts
  - State administrators
  - Nursing home leadership
  - Hospital and other clinical leaders
- Comprehensive literature review
- Data analysis

Key Findings and Recommendations Overview

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Key Findings Overview

Testing and Screening

- Testing guidelines frequently change
- Wide variation in the timeliness of test results
- Screening visitors and vendors varies depending on prevalence rates
- Pooled testing is a best practice to address testing capacity concerns

Staffing

- Staffing shortages occurred because of illness or fear of COVID-19
- Staff are increasingly becoming burned out
- Proper infection prevention only possible with adequate staff

Mental Health, Visitation, and Other Health Care

- Infection prevention measures led to restrictive visitation policies with reported negative impacts on mental and physical health
- Visitation policies not implemented consistently
- Lack of clear guidance on presence of ancillary providers

Resident Safety

- Residents can be safely cared for in nursing home settings with: adequate PPE, cohorting, testing, and other infection control protocols in CMS and CDC guidance
- National research shows that nursing home chains may have access to PPE and other resources at the corporate level.

Recommendations Overview

Structural	Process	Access to Mental Health, Visitation, and other Health Care	Operational
• Hubs, • Resident cohorting, • Hospital discharges, • Continuity of care between hospitals and nursing homes, • Home and community-based services	• Guidance and training, • PPE supplies and processes, • Screening and testing, • Staffing	• Behavioral health and ancillary services, • Visitation, • Collaboration with managed care organizations	• Administrative functions

Interim Hub Evaluation

MDHHS Hub Strategy Was Executed in a Crisis Situation and Was a Logical and Appropriate Response to the Surge

21 regional COVID-19 nursing home hubs established in mid-April:

5,187 COVID-19 admissions to Michigan nursing homes from hospitals and other facilities from April to August 19th.

3,661 admissions to non-hubs; 1,526 admissions to hubs

Selection criteria informed by federal guidance but constrained by urgency and facility availability. Criteria used: space to cohort, dedicated and sufficient staff, PPE supply, and LARA data

Hub performance variable but, overall, hubs had a lower percentage of deaths among residents with COVID-19 during this time: hubs **17%** compared to non-hubs **26%.***

MDHHS Hub Strategy Was Executed in a Crisis Situation and Was a Logical and Appropriate Response to the Surge (continued)

COVID-19 infection rates in nursing homes correlated with staff infection rates; this was consistent with community prevalence.*

No significant evidence of transmission of COVID-19 between patients admitted from hospitals to nursing home residents in hub facilities.*

Nursing home resident COVID-19 prevalence positively correlated with county COVID-19 prevalence rates for both hub and non-hub nursing homes.*

* More data is needed to draw a definitive conclusion.

Additional Observations

- National research shows no correlation between CMS overall 5-Star quality ratings with COVID-19 death rates
- National research shows a strong correlation between the staffing component of the CMS quality rating system and positive nursing home performance overall
- Federal and State guidance to hubs unclear and changed over time
- Interviewees reported variable hub performance: some used best practices consistently; others challenged by lack of PPE and staffing

Recommendations for moving forward

Structural Approach to Care for Long Term Care Patients with COVID-19

Structural Approach Should Be Flexible, May Vary by Region

Approach should consider time needed for deployment

Flexibility and tiered approach is needed to address COVID-19 prevalence rates and hospital and long term care capacity by region

Recommendations

A dedicated COVID-19 facility is not needed: separate unit/wing or dedicated hub can be safe with adequate PPE and testing

The most flexible approach is a combination of existing nursing home capacity with safe cohorting structures and a hub structure

Structural Approach to Care for Long Term Care Patients with COVID-19

Hubs

Recommended Hub Structure and Supports Going Forward

Enhance regional hub structure

- Enhance hub selection process and oversight
- Require on-site (or a combination of on-site and virtual) oversight on a weekly basis
- Clarify and share survey require-ments with hubs in advance of survey and review

Enhance in-person training

- Leverage strike team approach
- Use IPRAT, LARA, and partner hospitals for training resources and implementing guidance

Use federal funds

- Assess and leverage all available federal funding
- Prioritize hub nursing homes along with hospitals for PPE supplies and testing

Evaluate and support hubs

- Create capacity for MDHHS to support hubs in improving data reporting, and compliance with guidance for PPE, testing, and staffing

Proposed Hub Selection Criteria

1. Demonstrated ability to meet or exceed CMS / CDC guidelines based on a coordinated nursing home survey completed by LARA in collaboration with MDHHS, and program design including, but not limited to:
   a. Ability to cohort residents in a separate wing or floor with different entrances and exits for traffic flow
   b. Dedicated staff to the COVID-19 unit (can only work on unit and must not work in multiple facilities)
   c. Documentation of adequate and consistent supply of PPE
   d. Documentation of training for both clinical and non-clinical staff on appropriate infection protocols, cohorting, and use of PPE

Proposed Hub Selection Criteria (continued)

2. In facilities with more than five cases of COVID-19, a historical COVID-19 death to case ratio that meets a minimum threshold
3. Documentation that the facility has a communication/continuum of care plan with referring hospital(s) and a communication plan for staff, residents and families
4. Documentation that the facility achieves at least 3 out of 5 stars on the CMS rating for staffing measure

Structural Approach to Care for Long Term Care Patients with COVID-19

Resident Cohorting

Resident Cohorting* Should Follow Best Practices

Cohorting plan should be in place early (before a case of COVID-19 arises)	Three cohorts: positive, negative, and quarantine (PUI). They should not be allowed to intermingle
Recommendations	
Cohorting on a separate floor is best when possible. Separate wings/units are safe with adequate PPE	Considerations for each facility's plan and their ability to keep COVID-19 patients in the facility should be decided on an individual facility basis

* Grouping residents together who have the same COVID status: positive, negative or quarantined

Structural Approach to Care for Long Term Care Patients with COVID-19

Hospital Discharges

Hospital Patients Can Be Discharged to Nursing Homes Safely

- Maintaining COVID-19 positive patients in hospitals for the full recommended CDC isolation period is best, but often inconsistent with reimbursement policies of payers and capacity needs for other patients
- For patients that have not completed the full recommended CDC isolation period (10 days) but no longer need hospital level care, transfer to a hub is preferred

Hospital Patients Can Be Discharged to Nursing Homes Safely (continued)

- If a hub transfer is not possible or desirable for specified reasons, patients can be transferred to other nursing homes if facilities self-certify that they meet all of the following criteria:
  1. Ability to cohort patients per CDC guidelines
  2. Adequate PPE
  3. Documentation of staff training on appropriate infection control, cohorting and use of PPE
  4. Documentation that the facility has a communication/continuum of care plan with referring hospital(s) and a communication plan for staff, residents and families
  5. Meets or exceeds a CMS 2-star rating for the staffing measure
  6. Historical performance on a death rate to case rate ratio that is set at a certain level, excluding hospice and DNR patients (*requires adequate data reporting)
  7. Not ”COVID naïve”, COVID naïve facilities are those that have not had any COVID-19 patients during this pandemic

Structural Approach to Care for Long Term Care Patients with COVID-19

Continuity of Care Between Hospitals and Nursing Homes

All Nursing Homes Should Have Formal, Collaborative Arrangements with Hospitals for COVID-19 Patients

1. Care coordination and continuity of care plans should be required
2. Hospitals can provide back up support for testing, where available
3. Hospitals can provide back up PPE, where available
4. Hospitals can provide training and recommendations on infection control
5. MDHHS should work with MHA and nursing home associations to develop a collaborative system

Structural Approach to Care for Long Term Care Patients with COVID-19

Home and Community-based Services

Home and Community-based Settings Can Be a Safe Alternative to Nursing Home Care

- Support state Medicaid programs (MI Health Link / PACE / MI CHOICE) to increase options for home-based services for beneficiaries
- Contracting MCOs/ICOs should work with hospitals to facilitate discharge of eligible COVID-19 patients to home settings, including care coordination and supports
- For community-based COVID-19 cases that do not require hospitalization, support health plans in providing adequate HCBS and PPE supplies – including nutritional supports delivered to homes for members

Process Recommendations

Process Recommendations

Guidance and Training

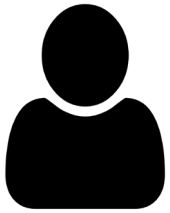
Long-term Care Providers Need Better Tools to Follow Federal / State Guidance

MDHHS should centralize the tracking and consolidation of federal and state guidance for nursing homes

MDHHS should review CMS and CDC guidance and determine whether any components should be mandated through the State Medicaid Plan Amendments

MDHHS should develop and disseminate key elements of guidance in easy to use format (e.g. checklist) for local public health and long-term care providers

Clear, Frequent, Onsite Training and Education Is Necessary



MDHHS should establish weekly “huddles” between nursing homes and MDHHS to share information

Build on Médecins Sans Frontières training / tool modules:

- Expand to other nursing schools
- Ensure non-punitive approaches
- Separate non-clinical and clinical staff

Establish more Infection Prevention Resource and Assessment (IPRAT) teams and provide more in-person technical assistance

Process Recommendations

PPE Supplies and Procedures

Improve PPE Preparedness for Long-term Care

- Use PPE reported data to support statewide tracking and distribution
- Track all available federal PPE supplies and PPE funding and communicate to nursing homes
- Develop process to share PPE between facilities if cluster outbreaks occur, facilitated by MDHHS with voluntary participation by nursing homes and hospitals

Process Recommendations

Screening and Testing

Testing capacity needs to be expanded and information on availability needs to be better shared

1. Michigan should use pooled testing in areas where prevalence is less than 30%, adjusted according to the likelihood of a positive test
2. Testing supplies should be directed to areas based on community and nursing home prevalence
3. MDHHS should update staff and stakeholders regarding new federal testing guidelines for nursing homes announced (but not yet issued)

Process Recommendations

Staffing

Staff Safety and Adequacy Must Be a Priority

1. Increase staff compensation (e.g. additional hazard pay)
2. Require nursing homes to have a plan to address staff burnout through additional supports (e.g. wellness resources, EAP, and occupational health and sick leave)
3. MDHHS/Michigan Works/MHA develop system connecting furloughed hospital staff to open positions in nursing homes
4. Make nursing homes aware of Rapid Response Staffing Resource and expand to additional counties

Some Staff Structures Can Better Support Resident Safety

1. A full-time Infection Preventionist position without other job responsibilities is preferred
2. State policy is needed to prohibit nursing home staff from working at multiple facilities (with some exceptions)

Access to Mental Health, Visitation, and Other Health Care

Nursing Home Residents Need Better Access to Behavioral and Other Health Care Services

- Require and approve nursing home plans that ensure adequate access (e.g. consider in-person where needed) to ancillary health care services, (PT, OT, dental, etc.) and relevant research
- Require and approve nursing home plans to ensure adequate access to address residents' BH needs (individual care plans for psychosocial needs)
- Enable non-COVID nursing home residents to socialize with each other to reduce social isolation, as long as there is adequate testing and infection prevention control

Access to Mental Health, Visitation, and Other Health Care

Visitation

"It's a balance between resident rights and resident safety…

Prolonged focus on safety resulting in prolonged isolation is worrisome…

Some states can start reopening facilities to visits safely and thoughtfully."

- Interviewee

Visitation policy should be resident-centered with consideration of both safety and psychosocial well-being

1. State visitation policy needs to be communicated on an ongoing basis so it is more transparent and clear to nursing home residents and their families
2. In areas with low community spread, nursing homes should identify 1-2 individuals as designated visitors for each resident. Designated visitors must undergo training on infection control practices prior to their first visit and use PPE.
3. Nursing homes that follow all visitation guidance should be assured they will not be cited for an adverse event as a result of visitation

Access to Mental Health, Visitation, and Other Health Care

Collaboration with Managed Care Organizations

Managed Care Organizations Can Be Partners to Nursing Homes and the State

1. The state can reduce the administrative burden on MCOs for COVID-19 members to facilitate access and care management services
2. The state should collaborate with MCOs to develop value-based incentive structures for nursing homes to help with:
   - Expedited testing and lab processing
   - PPE acquisition and distribution
   - Financial incentives to improve quality and access

Operational / Administrative Functions

Data reporting from nursing homes must be improved to support State management of COVID-19 outbreaks

1. The state should clarify for nursing homes how and what they should report; and, should perform routine data quality and validation checks
2. The state should expand its analytic capabilities to support targeted interventions, including technical assistance and local public health services; tracking PPE and staffing shortages; and program evaluation
3. MDHHS should explore federal funding opportunities to strengthen nursing home data quality

Intra and inter-departmental and stakeholder collaboration is needed

1. Communication between and within state departments needs to be strengthened; policy needs to be aligned and implementation needs to be better coordinated
2. Stakeholders should continue to be engaged to ensure multiple perspectives are taken into account in the development of state guidance and policy

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