MICHIGAN NURSING HOMES COVID-19 PREPAREDNESS TASK FORCE

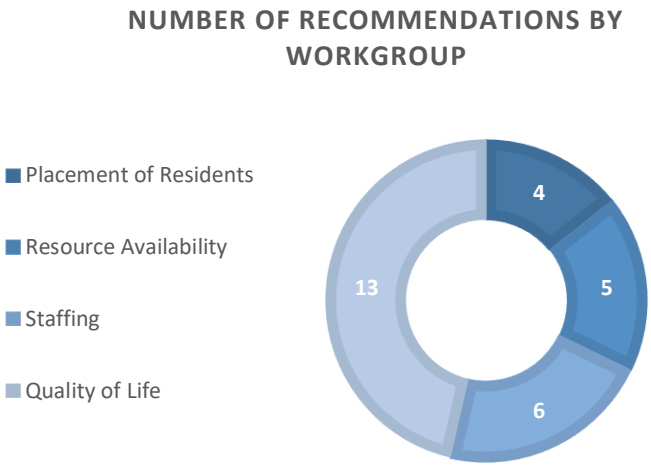
FINAL RECOMMENDATIONS

August 31, 2020

Contents

Executive Summary

The Michigan Nursing Home COVID-19 Task Force brought together many subject matter experts from across the state to participate in **39** days of intensive collaboration to create and endorse **28** final recommendations for Governor Whitmer in order to inform the state's response for a potential second wave of COVID-19.



High Level Recommendations

Resource Availability

- Improve coordination of personal protective equipment (PPE) distribution and allocation
- Improve coordination, prioritization, and procurement of testing supplies
- Decrease reporting burden on nursing homes
- Designate labs for Nursing Homes
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- Create a new CNA website with updates to existing LARA resources
- Conduct a series of Public Service Announcements
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- Establish a formal and identified CNA career ladder

Placement of Residents

- Identify and coordinate with hospitals with excess surge capacity
- Adaptions of the regional hub program to create Care and Recovery Centers with updated guidance and protocols
- COVID-19-positive admissions into facilities not designated Care and Recovery Centers in exceptional circumstances
- Continue to explore options of creating dedicated facilities/alternative care settings

Background

The burden of the novel coronavirus has been disproportionately and tragically borne by older adults, who constitute an overwhelming majority of fatal cases in Michigan. As of July 14, over 32 percent of cases and more than 85 percent of deaths were among those ages 60 and older. To protect the health and safety of our state and each other, we must continue to aggressively pursue solutions that curb the devastating impact posed by this pandemic.

In April, the Michigan Department of Health and Human Services (MDHHS) launched the COVID-19 Regional Hub strategy. These facilities have been dedicated to caring for COVID-19-affected long-term care facility residents who no longer need hospitalization, or to individuals who have not been hospitalized and cannot be safely isolated or cared for in the nursing facility where they live. With specialized staffing, sanitation, and reporting requirements, each Regional Hub acts as another support in the continuum of care for all long-term care facility residents. The Department has begun the process of decommissioning some hub facilities due to decreased demand, allowing for the reprioritization of resources and efforts in areas with the greatest need.

Protecting the health, safety and wellbeing of seniors and the most vulnerable residents remains a top priority. But the challenges involved in preventing the spread of COVID-19 in nursing homes are formidable including national supply chain shortages of personal protective equipment (PPE) and testing supplies, staffing challenges, and increased infection control needs. Federal leadership on how best navigate the COVID-19 pandemic in nursing homes has been in short supply. Although Michigan has weathered an initial wave of COVID-19, available data and research suggests the virus is surging in other parts of the country. A second wave of COVID-19 in Michigan therefore remains a deadly threat, especially to nursing home residents.

Purpose

The Michigan Nursing Homes COVID-19 Preparedness Task Force was created by Governor Whitmer's Executive Order No. 2020-135 as an advisory body in the Department of Health and Human Services to adequately inform the state's response to a potential second wave of COVID-19. The Task Force is charged with coordinating across state government and with industry stakeholders to ensure a broad range of input from relevant entities, reporting on best practices to minimize the spread of COVID-19 in nursing homes and provide appropriate and timely technical assistance to nursing homes.

Guiding Principles

Using the best available clinical information, public health, epidemiological science, gerontological research, and most recent Center for Disease Control (CDC) guidance, Michigan will:

1. Prioritize health and safety of long-term care residents and staff through education, resources, and testing
2. Prevent and mitigate the spread of COVID-19 in long-term care facilities
3. Partner across state agencies, local health departments and long-term care facility providers to maintain high quality resident care
4. Inform stakeholders about the impact of COVID-19 on long-term care facilities

Goals

This Task Force will aim to:

- Produce a recommendation to the governor for an action plan on how to prepare nursing homes for any future wave of COVID-19 cases by August 31, 2020

- Ensure adequate testing efforts in facilities across the State
- Limit the spread of COVID-19 infection to residents and staff
- Provide continuity of care for non-infected residents
- Provide support for facilities to keep their staffing levels up
- Secure access to personal protective equipment needed in facilities
- Provide resources and technical assistance to facility staff on infection prevention, resident care, and overall resident well-being
- Build and maintain enough bed capacity for residents with COVID-19 who do not require acute care in the hospital
- Explore opportunities to secure adequate financial resources are in place to implement recommendations

Task Force Membership

Member	Role
Betty Chu, M.D.	Task Force Co-chair
Hari "Roger" Mali, II,	Task Force Co-chair
Trece Andrews	Member
Senator Rosemary Bayer	Member
Renee L. Beniak	Member
Director Robert Gordon	Member
Director Orlene Hawks	Member
Ann M Hepfer	Member
David E. Herbel	Member
Alison E. Hirschel	Member
Steven M. Kastner	Member
Representative Leslie Love	Member
Preeti N. Malani, M.D.	Member
Mia K. Moore	Member
Salli Pung	Member
Melissa K. Samuel	Member
Kari L. Sederburg	Member
Melissa Seifert	Member
Senator Curt VanderWall	Member
Representative Hank Vaupel	Member

Workgroups

In order to fulfill this charge and maintain the urgency to address the ongoing public health crisis, Task Force members agreed to establish four workgroups that could simultaneously convene and focus on each critical piece of the overall nursing home COVID-19 preparedness strategy. Workgroups were created on the topics of staffing, quality of life, resource availability, and the placement of residents.

The purpose of these workgroups is to determine through its collective wisdom, the best policy and implementation recommendations to put forth for final review and endorsement by the Nursing Home COVID-19 Preparedness Task Force. Each workgroup was supported by several State of Michigan (SOM) staff members ranging from administrative support to departmental subject matter experts. In addition to departmental staff, each workgroup was led by a task force member and included up to ten external

subject matter experts. The ten external subject matter experts were either task force volunteers or were recommended by task force members and selected by the task force co-chairs.

Membership Selection Considerations

SOM staff collected workgroup membership recommendations via an online survey tool whereby task force members could volunteer themselves or other colleagues to participate on one of the four workgroups. One task force member on each workgroup volunteered to be the workgroup lead. Most individuals that volunteered to participate were placed on either their first or second choice of workgroup. A very small number of individuals were unable to participate on a workgroup due to the overwhelming interest in workgroup participation which exceeded the ability to include everyone. Because some workgroups received more than ten membership recommendations, the task force co-chairs supported the selection of the ten members. Items for consideration of selection included:

- Relevant experience with the workgroup subject matter or lived experience
- Willingness to abide by the participation commitment expectations
- Sector diversity among members
- Regional diversity of members
- One representative per organization per workgroup

Reporting Structure

The workgroup leads hosted weekly meetings with their respective workgroups to facilitate discussion and collaboration on recommendations for consideration by the task force. Weekly report-outs were given on workgroup progress, emerging recommendations, and sectoral interdependencies to the task force each week. This gave the task force the opportunity to ask questions and prompt discussion on high priority considerations emerging from the workgroups. This created an efficient feedback loop for task force input and workgroup development of recommendations. Workgroup recommendations were submitted via an online survey tool and reviewed multiple times by the task force before final endorsement.

Timeline

- **June 26:** Executive Order 2020-135 released
- **July 7:** Task force membership appointed
- **July 23:** First task force meeting
- **July 27:** Workgroup interest survey closed
- **July 30:** Workgroup membership notified
- **August 4:** Workgroup meetings kick off
- **August 19:** Workgroups submit preliminary recommendations
- **August 20:** Task force members review preliminary recommendations at task force meeting
- **August 26:** Workgroups submit final recommendations
- **August 27:** Task force members endorse final recommendations at task force meeting
- **August 31:** Workgroup leads, task force co-chairs, and SOM staff meet to finalize final report & submit to the Governor

Final Recommendations

The following recommendations were produced by several diverse groups of subject matter experts, reviewed by departmental leadership, and endorsed by the appointees of the Michigan Nursing Home

COVID-19 Preparedness Task Force. Except for the third Placement of Residents recommendation: COVID-19-positive admissions into facilities not designated Care and Recovery Centers in exceptional circumstances, these recommendations were endorsed without objection within the task force. Some recommendations emphasize actions that are already underway, while others are aspirational and will require further consideration by different departments and legislative bodies to assess the required resources and operational challenges.

Resource Availability: Recommendation 1

Improve coordination of personal protective equipment (PPE) distribution and allocation

Shortages of PPE were a glaring issue from the very beginning of the public health emergency, particularly at the local level and in rural areas. Because many orders were based on population and facilities were already competing for limited amounts of available PPE, nursing homes with fewer residents were often restricted in purchasing power and lacked necessary supplies.

The workgroup recommends improving the coordination of PPE distribution and ensuring that nursing homes are prioritized. This will require improved supply-chain management and coordination between Regional Health Care Coalitions, Local Emergency Management, and the Federal Emergency Management Agency (FEMA). This can be accomplished by securing coordination agreements between suppliers and facilities that will allow nursing homes to purchase according to need during times of a state emergency or pandemic instead of basing supplies on previous ordering history. An inventory management system focused on nursing homes and a formula for determining nursing home need will also be necessary to ensure facilities maintain a stockpile of PPE.

State assistance with emergency purchasing for nursing homes is also recommended to ensure that facilities are not subjected to price gouging and help them avoid competition with larger purchasers. The group further recommends an extensive evaluation of how FEMA, state, local emergency management, and health care coalitions conduct supply management and prioritize supplies during the pandemic.

Resource Availability: Recommendation 2

Improve coordination, prioritization, and procurement of testing supplies

The workgroup also identified a need to improve the coordination, prioritization, and procurement of laboratory testing supplies for nursing homes. First, nursing homes need to be supplied with adequate testing equipment in order to meet CDC guidelines and fulfill obligations mandated by executive orders. Second, tests need to be prioritized and processed in order to meet rapid turn-around times for reporting. The workgroup recommends a coordinated laboratory system across the state that prioritizes nursing homes. The workgroup believes this can be accomplished by dedicating the resources and testing capabilities of certain laboratories or laboratory systems for the sole purpose of processing nursing home specimens (see Recommendation 4).

The workgroup further recommends that the state shift its focus from pop-up community testing and prioritize weekly testing in nursing homes. This would need to be done in partnership and coordination with the National Guard and other entities that have been involved in the state's testing strategy. Because the National Guard will cease testing at the end of the calendar year, the state's plan for testing in 2021 needs to be communicated with nursing homes. Finally, an evaluation of testing in nursing homes is recommended in order to assess ways that testing with third parties can be improved.

Resource Availability: Recommendation 3

Decrease reporting burden on nursing homes

In compliance with CDC and DHHS requirements, nursing homes have been subject to burdensome reporting requirements that have strained staff resources and limited the ability of facilities to address resident needs. Infection control staff are being diverted from auditing the safety of facilities in order to focus on daily reporting. However, the data reported by these facilities has helped inform the state's response and improved overall understanding of the pandemic.

The workgroup recommends that DHHS explore opportunities to reduce the reporting burden while maintaining the ability to respond quickly in a crisis. This can be done by switching reporting requirements to align with the regional level of risk based on the MI Safe Start plan. Facilities in regions with a low or moderate level of risk should only be required to report on a weekly basis, while nursing homes in regions with a high level of risk should report on a daily basis. This will provide nursing homes with some relief without depriving the state of the information necessary to manage its response to the public health emergency.

The workgroup further recommends an evaluation of what information is actually being utilized and requests funding to support staffing needs. First, facilities are reporting a great deal of information to the state, its departments, and other entities such as Medicaid. However, there has been no comprehensive analysis of whether this information is important, effective, or actionable. Second, as previously stated, compliance with the increased reporting is a strain on human resources and nursing homes need additional funding to pay for the requisite staff.

Resource Availability: Recommendation 4

Designate labs for nursing homes

Nursing home reports indicate that testing is being conducted weekly and results are reported after 72 hours. This is incongruent with best practices for contamination management that require rapid identification of infection and quick action steps to quarantine and isolate COVID-19-positive residents. Without access to testing supplies or laboratories that prioritize specimens from nursing homes, facilities have been forced to rely on the National Guard for diagnostic tests to manage the spread of illness.

As previously stated, the workgroup recommends that the state dedicate certain laboratories or laboratory systems that will prioritize and process diagnostic tests from nursing homes. This will require the identification of laboratories or laboratory systems with reliable procurement processes for obtaining essential resources and the equipment and staff necessary to process the high-volume of tests from nursing homes, which can reach up to 50,000 per week. The workgroup also requests that the state outline its long-term strategy to continue paying for diagnostic tests (see Recommendation 5) and help to facilitate agreements between nursing homes and testing facilities.

Resource Availability: Recommendation 5

Secure funding for continued testing of nursing home residents

The cost of testing nursing home residents and staff at the rate required would be devastating if not for funding currently available through state and federal sources. However, funding provided by the Coronavirus Aid, Relief, and Economic Security (CARES) Act will expire at the end of this calendar year. The workgroup recommends that a consistent funding stream be secured to continue diagnostic testing of nursing home residents and staff as considered a standard of care for the management of COVID-19.

A permanent solution should include the exploration of federal (including Medicare and Medicaid), state, local, and private funding sources. The funding will allow facilities to pay for essential supplies, staffing expenses for testing and reporting, and any additional charges from laboratories.

Quality of Life: Recommendation 1

Outdoor Visits

The workgroup recommends that outdoor visits be allowed and strongly encouraged for residents in long-term care facilities for enhancement of quality of life. We recommend clarification by FAQ to the MDHHS Epidemic Order, or by issuance of new MDHHS Epidemic Order that outdoor visits are allowed and strongly encouraged by providers. We further recommend provision of clear guidance to providers that outdoor visits should align with other reopening plan guidance developed by the state with appropriate infection control precautions for residents and their visitors. Guidance should include requirements for scheduling visits, health screening of visitors, logging visits for tracing purposes, hand hygiene, physical distancing, face masks (as tolerated) and disinfecting visitation areas as per current CDC guidance. Residents should be given the choice to participate or not in a visit in accordance with state and local orders and the right to privacy during the visit must be honored.

To support outdoor visitation, the workgroup recommends MDHHS grant Civil Monetary Penalties (CMP) funds to nursing home providers for the purchase of equipment which could also be used indoors during inclement weather. Acquisitions will be considered for supportive options for residents unable to wear a mask or those who have hearing loss for whom masks impede communication with visitors. Considerations for acceptable use of funds to include visitation booths, tabletop plexiglass shields, personal hearing amplifiers, and adaptive equipment to support residents using sign language. Additionally, we recommend consideration for use of interpreters.

We recommend MDHHS or its designee conduct provider training on new Executive Orders, policies or guidelines.

Quality of Life: Recommendation 2

Small-group Non-contact Activities

The workgroup recommends nursing facilities provide small-group non-contact activities for residents to facilitate resident opportunity to participate in meaningful activities thereby reducing the effects of isolation. This is supported by CMS' reopening guidance which allows for resumption of activities in a phased approach.

To effect and support implementation of this recommendation the workgroup advises adopting the recommendations of the High Acuity Congregate Care setting workgroup related to activities. Additionally, we recommend updating language in section II.2 of Executive Order 2020-169 and in a new Executive Order to allow and strongly encourage facilities to provide group activities with appropriate precautions as outlined in the Congregate Care Setting recommendations.

We recommend MDHHS or its designee conduct provider training on new Executive Orders, policies, or guidelines.

Quality of Life: Recommendation 3

Communal Dining for Residents

The workgroup recommends allowing limited communal dining for residents to reduce the effects of isolation. This is consistent with CMS' reopening guidance which allows for resumption of communal dining in a phased approach.

To effect and support implementation of this recommendation, the workgroup advises adopting the recommendations of the High Acuity Congregate Care Setting workgroup on communal dining. Additionally, we recommend updating language in section II.2 of Executive Order 2020-169 and in a new Executive Order to provide communal dining with appropriate precautions as outlined in the Congregate Care Setting recommendations, and MDHHS or its designee conduct provider training on new Executive Orders, policies or guidelines.

Quality of Life: Recommendation 4

Indoor Visitation Participation Opt-in

The workgroup recommends that all residents are provided with the option to participate in indoor visitation. This is consistent with CMS' reopening guidance which allows for resumption of indoor visits in a phased approach.

To effect and support implementation of this recommendation, the workgroup advises adopting the recommendations of the High Acuity Congregate Care Setting workgroup on indoor visits. Additionally, we recommend updating language in section II.2 of Executive Order 2020-169 and in a new Executive Order to allow and strongly encourage facilities to provide for indoor visits. Residents must be given the option to participate or not in the visit and the resident's right to privacy during the visit must be honored.

The workgroup recommends creation of state-developed training for visitors which includes, but is not limited to, the use of face masks during visits, hand hygiene, requirements for physical distancing, health screening requirements, logging of visitor entrance/exit, disinfecting of visitation area, reporting of suspected COVID-19 exposure or illness following the visit, and other requirements to ensure consistent training statewide for visitors. This training should be made easily and readily accessible for facilities to apply with visitors prior to an in-person visit. Additionally, the workgroup recommends MDHHS or its designee conduct provider training on the new Executive Orders, policies, or guidelines.

Quality of Life: Recommendation 5

Resident Small Group "Pod" Opt-in

The workgroup recommends that residents be provided the option to engage in small groups as a "family" or "pod" within the facility. This would permit residents to feel part of a "community" thereby reducing the effects of isolation, particularly for those residents without external supports. The workgroup identifies that providers may need guidance on developing facility "families/pods."

The workgroup recommends issuance of new Executive Order requiring facilities to offer resident the opportunity to participate in small groups (families or pods) to allow for enjoyment of shared activities of the residents' choice, such as community dining, group activities, and other daily living experiences such as conversations, reading the newspaper, watching TV, opening mail, and sitting outside together. Guidance should be provided to facilities on the development of families/pods. Guidance should outline: voluntary participation basis, defined/limited number of residents per pod, inclusive of residents from same facility unit, assignment of designated staff (if feasible), and education for residents on infection prevention including hand hygiene requirements, use of face mask/covering, and minimal sharing of items.

We further recommend that providers present the families/pods option to residents and allow residents to determine if they wish to participate and in which family/pod if multiple groups are available. Providers shall ensure that residents recovering from COVID-19 or those determined to be "negative" following quarantine are informed of the families/pods option when moving to the non-COVID-19 area of the facility.

We recommend MDHHS or its designee conduct provider training on new Executive Orders, policies, or guidelines.

Quality of Life: Recommendation 6

Increased Virtual Visitation Opportunities

The workgroup recommends supporting increase in virtual visitation opportunities for residents regardless of COVID-19 status. Virtual visitation is especially important for residents who are COVID-19 positive or under observation as they do not have access to in-person visits. Virtual visitations can be a valuable opportunity to enhance resident quality of life, particularly in the event the state experiences a second surge in COVID-19 in which other types of visits are suspended.

We recommend that by new Executive Orders, policies, or guidelines providers will be instructed to include virtual visits in the care planning process for residents, to identify barriers and solutions to those barriers, and discuss resident's preferences for/election of virtual visitation. Further that MDHHS or its designee research and publish a list of electronic applications and other electronic platforms for families and residents to independently connect with one another to reduce the use of limited staff resources (i.e., GoToMyPC, Uniper, Oscar Senior, Log Me In). Published resources shall additionally leverage information available from clearing houses such as LeadingAge, Center for Aging Services Technologies (CAST), American Association of Retired Persons (AARP), and Consumer Voice, as examples. The workgroup recommends collaboration with Senator Bayer's project to expand internet access in long-term care facilities that currently have limitations or no internet available to residents.

Residents must be given the option to participate or not in the visit and the resident's right to privacy during the visit must be honored.

The workgroup recommends that MDHHS will notify nursing home providers of the availability of CMP funds to purchase additional electronic communication devices to support increased access to virtual visitation opportunities.

We recommend MDHHS or its designee conduct provider training on new Executive Orders, policies, or guidelines.

Quality of Life: Recommendation 7

Staff Access to Creative Engagement Ideas

The workgroup recommends nursing home staff be provided with resources to create meaningful activity options for residents. The workgroup identifies that it may be necessary for facilities to purchase additional equipment or access on-line resources to engage residents in activities.

To effect and support implementation of this recommendation, the workgroup advises adopting the recommendations of the High Acuity Congregate Care Setting workgroup on release of policy or guidance clarifying residents' right to participate in meaningful activities. Opportunities for engagement for provider consideration include:

1. On-line entertainment (It's Never Too Late – iN2L, music, movies, television shows, etc.)

2. Leverage recommendations from Certified Recreational Therapy Specialists, Teepa Snow, The Pioneer Network, AARP, and others for resident engagement ideas
3. Collaboration with local schools, churches and clubs to bring outdoor entertainment (i.e., bands, choirs, other entertainers) to the facility with proper physical distancing and weather permitting, or stream these performances through Zoom, Skype, Facebook or other platforms

We recommend MDHHS or Licensing and Regulatory Affairs (LARA) to make the recording of LARA's Joint Provider/Surveyor Training session on activities and communication available on state website for all long-term care providers to review and notify those providers of the way to access the recorded webinar. Additionally, MDHHS or its designee will conduct provider training on the new Executive Orders, policies, or guidelines.

Quality of Life: Recommendation 8

Support for Meaningful Engagement Activities

The workgroup recommends increasing resident supports for meaningful activities and engagement, especially for residents living with Dementia or other cognitive limitations. The workgroup identified that providers may need to purchase additional equipment or supplies to support provision of activities.

We recommend that policy or guidelines be developed that clarifies for providers that they may utilize visitation booths or designated areas, such as courtyard or visitation room, outfitted with barriers to maintain physical distancing in order to mitigate need for masks which may be difficult for residents living with Dementia or other cognitive limitations. The workgroup recommends amending language in section I of Executive Order 2020-156 via new Executive Order to allow and strongly encourage the use of volunteers as essential workers, under requirement of appropriate infection control training which would allow volunteers to routinely enter the building to support daily activities. Volunteers may be inclusive of previous volunteers, family members, students/interns. Activities may be small-group or one-one.

The workgroup recommends expanding funding in nursing homes to allow for robotic pets and other creative interventions that are effective to reduce isolation on residents. Further, MDHHS will request CMS allowance for same flexibilities to the CMP review and approval process as was granted for electronic communication devices. We recommend MDHHS announce to nursing home providers the opportunity to apply for funds for resident engagement through purchase of specialized equipment to reduce isolation and in particular, support for residents living with Dementia or other cognitive limitations.

We recommend that guidance outline that providers can utilize It's Never Too Late – iN2L, Music and Memory or similar programs for meaningful engagement. As touch can be of benefit to many residents, including those living with Dementia, the workgroup further recommends that providers consider resident benefit from a hugging wall.

We recommend MDHHS or its designee conduct provider training on new Executive Orders, policies, or guidelines.

Quality of Life: Recommendation 9

Ancillary Service Providers

The workgroup recommends designating ancillary service providers as essential, allowing them to work in facilities provided they have been tested and follow infection control protocols. Ancillary service providers shall be determined essential based on the resident's need to receive the service and the negative impact (physically, emotionally, psycho-socially) on the resident when the service is not provided. The workgroup feels this recommendation is necessary to implement at a high priority so that residents will not experience significant declines before visitation is offered as an intervention.

We recommend that language in section I.5 of Executive Order 2020-169 be amended with new Executive Order to include medical service providers such as hospice, podiatry, dental, DME, mental health, speech pathology, occupational therapy, physical therapy, and other specialists in the definition of essential workers. Essential nature of the service shall be further supported when there is an actual or potential negative impact on the resident when the service is not provided in-person.

The workgroup further recommends updating language in section I.5 of Executive Order 2020-169 with new Executive Order to expand inclusion of non-medical service providers such as clergy/religious or hairdresser/barber when there is actual or potential for negative impact on the resident when service is not provided or resident does not benefit from remote service delivery (i.e., communion or anointing of the sick/last rites).

We recommend that language be included in new Executive Order to clarify the potential for or actual negative impact includes but is not limited to a decline in mental status, weight loss, increased agitation or confusion, hastened medical decline, heighted or unexpected disengagement, or new behaviors not present prior to COVID-19 pandemic or increased behaviors. We recommend that language in new Executive Orders direct facilities in monitoring and reporting of resident status changes and utilization of person-center care planning process to address concerns with input from residents or their family/legal representative, and further that allowing ancillary service providers must be exhausted prior to increasing medications.

The workgroup recommends that MDHHS provide training to providers on assessing for resident decline during COVID-19 including engagement of physician once slight change in status is identified by staff or family members. Additionally, MDHHS or its designee will conduct provider training on new Executive Orders, policies, or guidelines.

Quality of Life: Recommendation 10

Visitation Volunteers

The workgroup recommends that nursing home providers shall be allowed and strongly encouraged to engage volunteers to serve as facilitators of in-person visits or virtual visits (Visitation Volunteers). Leveraging Visitation Volunteers will allow residents to experience more visitation opportunities and

reduce strain on limited staff resources dedicated to resident care and services. The workgroup identifies that providers may need guidance on creating a Visiting Volunteers program.

We recommend amending language in section I.5 of Executive Order 2020-169 to expand the definition of essential workers to include Visitation Volunteers who will, at a minimum, assist in scheduling visits for residents, conduct screening of visitors, escort visitors or residents to visitation location, and randomly monitor visits for infection control compliance.

The workgroup advises that Visitation Volunteers be recruited from family members, volunteers, interns/students or community groups offering volunteer services. Individuals who are considered medically high-risk for COVID-19 per CDC's guidelines shall not be permitted to serve as a visitation volunteer. Providers will train Visitation Volunteers on infection control requirements including but not limited to use of PPE, hand hygiene, physical distancing, health screening of visitors, disinfection of visiting area (if not done by housekeeping staff), logging of visits for tracing purposes, transporting residents (excluding physical transfer of resident out of bed if care plan requires staff assistance), and how to report concerns to facility staff.

It is the recommendation of the workgroup that Visitation Volunteers work with provider to develop procedures for scheduling visits for residents and supporting residents to participate in visits. Providers are advised to develop a consistent visitation policy for residents and families encompassing days of the week, hours of operation, number of concurrent visitors, and limitations to visitors other than health screening. Policy shall allow for flexibility in deviation for extenuating circumstances.

We recommend MDHHS or its designee conduct provider training on new Executive Orders, policies, or guidelines.

Quality of Life: Recommendation 11

Off-campus Health and Wellness Visits

The workgroup recommends providers support residents attending off-campus appointments for medical (dental, optical, etc.) and mental health purposes when telemedicine or telehealth is not feasible.

We recommend issuance of policy or guidelines to clarify that residents have the right to attend off-campus medical and mental health appointments and shall clarify that residents who leave for an off-campus appointment have the right to return to the facility and may be subject to transmission-based precautions upon return or, if exposed to COVID-19 will be quarantined per current CDC guidance.

The workgroup recommends providers be required to discuss guidelines for reducing possible exposure by wearing a face mask, physically distancing (no physical contact unless necessary with healthcare provider), and hand hygiene, and further, upon exposure, the possibility of quarantine upon return to facility, including potential room change for the resident.

We further recommend providing clarification and guidance that family members or friends may transport residents if transportation can be done safely, and appropriate infection practices are followed.

We recommend MDHHS or its designee conduct provider training on new Executive Orders, policies, or guidelines.

Quality of Life: Recommendation 12

Window Visits

The workgroup recommends that MDHHS explicitly allow and strongly encourage window visits so that more residents will be provided the option to participate.

The workgroup identifies that clarification is needed in language of Executive Order 2020-156 as to meaning of "entering their facilities." By example, specifics shall be provided as to entering the campus, entering the building, and entering a resident room. Further clarification shall be provided to existing or new Executive Order whereby window visits are allowed when a barrier is maintained between the resident and visitor, and that accommodations shall be made for residents without access to ground floor window or window that does not open to an area accessible to the visitor. Accommodation may include utilizing a visitation room or space with a window or door access to visitor.

We recommend MDHHS or its designee conduct provider training on new Executive Orders, policies, or guidelines.

Quality of Life: Recommendation 13

June 30, 2020 Epidemic Order FAQ/Clarifications

The workgroup recommends providers receive clarification on the MDHHS Epidemic Order to support consistent implementation of the order.

To ensure current and future policy and guideline vehicles are in alignment with preceding recommendations and offer clarity to facilities related to implementation of quality of life activities, the workgroup recommends MDHHS conduct a thorough review of questions received directly or through other agencies regarding interpretation of the June 30, 2020 Epidemic Order. MDHHS will provide clarification of inquiries received and address inconsistency in application of the order reported to MDHHS. By example, MDHHS will clarify that residents have the right to go outdoors without having to quarantine upon return if they stay on campus for purposes other than an outdoor visit (i.e., smoking, reading a book, going for a walk, and other individual activities of choice). Providers should discuss with residents that if they leave the campus, they retain the right to return and may be subject to transmission-based precautions upon return.

The workgroup further recommends pivoting from use of "Compassionate Care" visit to Quality of Life and Social Connectivity Visit to address the common misinterpretation of visits as limited to end-of-life/imminent death scenarios.

The workgroup recommends issuance of Epidemic Order to require facilities to train visitors using state developed video on infection control requirements and require random monitoring of visits for infection control facilitation to reduce the strain on limited staff resources.

Additionally, the workgroup recommends for the effective implementation of this and all preceding recommendations, that MDHHS or its designee conduct provider training on current and future policy/guideline vehicles.

Staffing: Recommendation 1

Create a new CNA website with updates to existing LARA resources

One of the main issues facing Michigan nursing homes is a lack of qualified staff available to work in facilities, a problem further compounded by the public health emergency. In order to successfully recruit, train, and hire individuals as certified nursing assistances (CNAs), there needs to be a central repository of information and user-friendly resources easily accessible by the public.

The workgroup recommends that the Department of Licensing and Regulatory Affairs (LARA) update its public-facing website regarding CNA training programs to allow easier use by interested individuals, greater access to training programs and resources, and transparency for CNAs seeking employment. Updates could include:

- A list and/or map of all facilities with operational CNA training programs, with details on enrollment availably and job placement
- A list and/or map of all operational CNA testing sites
- A list and/or map of regions facing staffing shortages
- The staffing star-rankings from the Centers for Medicare & Medicaid Services for nursing homes

The workgroup also discussed the possibility of convening stakeholder focus-groups to better inform changes and offer potential additions.

Staffing: Recommendation 2

Conduct a Series of Public Service Announcements

In addition to improving the accessibility of available materials for individuals interested in pursuing healthcare careers, additional work is required to inform the public of the need for these positions to be filled.

The workgroup recommends a series of public services announcements to help drive individuals facing employment insecurity to the healthcare field. The campaign would also need to incorporate messaging that encourages those currently working as CNAs to support worker retention. Because there is a lack of data on nursing home staff related to recruitment and retention specific to Michigan, the workgroup also discussed the possibility of incorporating surveys on social media to help identify larger issues with the workforce that could support future, comprehensive efforts addressing staffing shortages.

Staffing: Recommendation 3

Ensure adequate access to training programs across the state

The public health emergency resulted in the temporary closures of many CNA training programs and testing sites during a time when they were needed most. Programs are also disproportionately spread across the state despite widespread need. For example, there are a dozen nurse aide training programs the City of Detroit alone while Region 12, which covers 8 counties in the Upper Peninsula, only has 14 programs available.

The workgroup recommends that the state work to ensure there is adequate access to training programs for individuals throughout Michigan. This can be accomplished by providing more information on available programs (see Recommendation 1), examining CMS staffing star ratings against the number of programs offered in the region to assess the level of access and need in an area, and the exploration of education alternatives such as virtual classrooms.

Staffing: Recommendation 4

Improve support of the physical and mental health for current staff

Healthcare workers face hazardous conditions, both physically and psychosocially, on a daily basis. The strain on CNAs in nursing homes has only be exacerbated by the public health emergency, staffing shortages, and limited employment benefits.

The workgroup recommends that nursing facility staff should be provided with adequate paid leave time for the duration of the public health emergency to mitigate the toll on their emotional and physical health. This will allow CNAs who fall ill or need time off due to personal issues the freedom to prioritize their own physical and mental health without jeopardizing the safety of residents who rely on staff for care. The workgroup further recommends expanding the $2-hour wage increase to all individuals working in nursing facilities.

Some facilities have explored the option of hiring a social worker or other employee dedicated to supporting staff wellness, either through grants or other programs. The workgroup did not reach consensus over whether the employment of mental and physical health professionals would be an effective measure to support the needs of nursing facility staff.

Staffing: Recommendation 5

Set minimum training standards for CNA preceptor training across Michigan

A CNA preceptor training program developed and currently offered by the Berrien, Cass, Van Buren Tri-County Office of MiWorks to residents in the south-west area of Michigan has been very successful. The

program trains experienced CNAs to act as preceptors that mentor upcoming peers, broken into two main components:

1. Training for preceptors utilizing the "In The Know Caregiver Training" platform, which includes approximately 10 hours of training. Once completed, participants are awarded with an "In The Know Caregiver Specialist: Peer Mentor" certificate that allows them to work with individuals coming up through the CNA Apprenticeship program
2. The CNA Apprenticeship program consists of 3 levels:
    a. Level 1: applicants are supported financially while completing a CNA training program
    b. Level 2: CNAs that have recently completed their program then participate in the 32-hour CARES dementia training and certification as a Dementia Specialist, as well as an additional 12-hour essential skills training and certification.
    c. Level 3: CNAs have the option to complete a 12-hour restorative care training or a 13-hour preceptor training.

Throughout the apprenticeship, applicants work closely with their preceptors and are supported financially to complete their training. This two-part program helps improve the skills of staff working in nursing homes, creates a career ladder for new and long-serving CNAs, and will help to standardize care in all nursing homes.

The workgroup recommends that LARA implement a standardized CNA preceptor training program for the entire state using the MiWorks Model.

Staffing: Recommendation 6

Establish a formal and identified CNA Career Ladder

Career ladders are an effective way to maximize the use of unlicensed workers, without replacing certified or licensed healthcare professionals, and help to improve employee retention. It further allows licensed nurses more time to perform higher-level clinical tasks such as assessments, patient education, and documentation of care. Career ladders can also be formalized, such as the articulation models outlined by some states in statute that are designed to move qualified and experienced workers from CNA to a baccalaureate-level registered nurse.

The workgroup recommends that a career ladder be developed for CNAs in Michigan, with specific elements to be identified by the task force.

Placement of Residents: Recommendation 1

Hospital Capacity

The workgroup recommends that MDHHS and LARA actively coordinate with healthcare systems, hospitals and other providers to self-select or identify facilities with excess surge capacity, including long-term acute care hospitals, specialty surgical hospitals, etc. We recommend that, whenever

possible, hospitals not discharge COVID-19-positive residents back to an originating nursing home if the patient has less than 72 hours remaining in the overall isolation period before they meet the criteria to discontinue transmission-based precautions. In support of this policy, the state should develop a funding model to adequately reimburse hospitals for any portion of the increased length of stay that does not qualify for reimbursement from Medicare, Medicaid, or commercial insurance carriers. Additionally, we recommend that hospitals be encouraged to maximize the use of swing beds through the use of the CMS 1135(b) waiver program, in areas of higher risk as determined by MDHHS.

Placement of Residents: Recommendation 2

Care and Recovery Centers

When the hospital options available pursuant to recommendation 1 are not feasible, the workgroup recommends using an adaptation of the regional hub program that incorporates updated guidance and protocols based on the research and findings from Center for Health and Research Transformation (CHRT) and the discussions and recommendations from the Placement of Residents workgroup and full task force. Under the new model, the State will identify criteria and procedures to approve facilities as Care and Recovery Centers. Facilities that were previously designated as hubs may, at their discretion, reapply to be designated as a Care and Recovery Center, subject to the new criteria. Previous designation as a hub does not guarantee selection as a Care and Recovery Center, and facilities that were not previously designated as hubs should also be encouraged to apply. The State should select a geographically diverse array of facilities that appear best suited to meet the State requirements, provide high quality care, and engage in rigorous and consistent infection control protocols.

During the designation process, consideration should be given to facility quality and survey history as well as other criteria set forth in the CHRT recommendations. The approval process should incorporate an on-site review of facility operations and physical plant characteristics. A virtual review could be employed in such instances where the Department determines an on-site review is not practicable. The review will assess the facility's ability to meet resident needs and engage in infection control protocols and assure the physical plant meets State guidelines, including, but not limited to, the ability to designate an entire wing, separate unit, or building for the care and isolation of COVID-19-positive residents. Additional requirements for Care and Recovery Centers must include but not be limited to dedicated staff who are assigned only to the COVID-19 unit; an appropriate, adequate, and consistent supply of PPE; and participation in weekly monitoring calls with MDHHS. The Care and Recovery Centers should also receive support in implementing infection control protocols and training for all on-site staff from the IPRAT team.

Care and Recovery Centers should be prioritized for timely testing results. Facilities approved to be Care and Recovery Centers shall be required to notify residents, family, and staff upon approval as a Care and Recovery Center. The workgroup further recommends that the State prepare a pamphlet/brochure to explain the Care and Recovery Center program to residents, their families, and the public.

MDHHS should conduct a thorough evaluation of continued financial support for designated facilities, including exploring a retention payment process in times of low census, in order to determine whether modifications to the previous funding model would increase the potential number of facilities interested

in being designated as Care and Recovery Centers. Additionally, the CRC program should include protocols to decommission CRCs when the bed capacity is no longer needed.

Placement of Residents: Recommendation 3[i]

COVID-19-positive admissions into facilities not designated Care and Recovery Centers in exceptional circumstances

The Task Force recommends that the hospital and Care and Recovery Center options be prioritized for the placement of COVID-19-positive individuals. However, in exceptional circumstances when these options are not practicable or able to best meet an individual's needs, the Task Force recommends that facilities that have experience in caring for COVID-19-positive residents be permitted to admit COVID-19-positive individuals, if they meet established criteria recommended by state/national experts. These criteria should include:

1. Documentation that the facility has the ability to cohort patients per CDC guidelines;
2. Documentation that the facility has adequate PPE and a reasonable strategy to maintain sufficient PPE;
3. Documentation that the facility has trained both clinical and non-clinical staff on appropriate infection protocols, cohorting, and use of PPE and has a plan to monitor ongoing compliance with all protocols;
4. In facilities with more than five cases of COVID-19, a historical COVID-19 death to case ratio at the facility that meets a minimum threshold, as determined by MDHHS in consultation with state/national experts;
5. Documentation that the facility has a communication/continuum of care plan with the referring hospital(s) and a communication plan for residents and families;
6. Documentation that the facility meets a minimum threshold, as determined by MDHHS in consultation with state/national experts, for the CMS star rating measure related to staffing.

Utilizing these criteria, the State should employ a process to review and approve facilities prior to the admission of COVID-19-positive individuals. A temporary, self-certification process should be permitted in times where demand for approval exceeds the state capacity to do so in a timely manner, as determined and publicly communicated by the State.

COVID-19-positive residents who are discharged from hospitals should not be sent to "COVID-19 naive facilities" (facilities that have not had COVID-19-positive residents) except in exceptional circumstances, as identified by the State in policy or guidance.

Placement of Residents: Recommendation 4

Dedicated Facilities/Alternative Care Settings

The workgroup recommends that the state continue to explore the option of creating dedicated COVID-19 facilities. This option presented substantial procedural challenges that may not allow for timely implementation if we are faced with a second wave this fall. The following, among others, are issues

that would need to be addressed to implement these options: licensing, management, certificate of need, staffing, resident transfer, procurement of supplies, and ancillary services. While these options may not be feasible for an upcoming second wave, the state should explore the necessary changes in policy that would allow for the establishment of these options in preparation of a future pandemic or surge, particularly in urban areas.

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[i] The members of the Resident Placement Workgroup were not able to reach consensus on a specific recommendation related to the admission of COVID-19-positive individuals at non-CRC facilities. The issue was presented to the full Task Force membership for discussion relative to the circumstances under which admissions into non-CRC facilities should be allowed. A lack of consensus on the specific criteria prompted a vote and the majority position is represented within this final recommendation.