Michigan Department of Health & Human Services

Guidance and Protocols

MDHHS Designated Care and Recovery Centers

Special Note: This guide is an iterative document that will be amended as new information is identified to support the operations of MDHHS Designated Care and Recovery Centers. MDHHS strongly encourages users to access this guide and associated materials through the website rather than downloading or printing local copies to ensure that the most up-to-date information is always used.

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CARE AND RECOVERY CENTER OVERVIEW

The purpose of this document is to provide guidance specific to the operations of Michigan Department of Health and Human Service (MDHHS) designated Care and Recovery Centers (CRCs). MDHHS has provided guidance to all long-term care facilities regarding operations during the COVID-19 public health emergency. The guidance provided in *Guidance to Protect Residents of Long-Term Care Facilities (Upon Readmission and Current Stay)* applies to all nursing facilities and other residential settings, including CRCs. This document provides the additional guidance relevant to a CRC.

The CRCs are designated facilities or units within existing nursing facilities to care for COVID positive patients discharging from a hospital or residents from long-term care facilities that are unable to care for residents with confirmed COVID-19 who have not met criteria for discontinuation of Transmission-Based Precautions, but do not require acute care provided in a hospital. CRCs have designated units to care for COVID-19-positive residents and have prioritized access to available Personal Protective Equipment (PPE) and COVID-19 testing kits and assistance as well as infection control training and technical assistance

CRCs must keep up to date with Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) guidance and recommendations related to COVID-19 and inform employees of any changes.

MDHHS will periodically reevaluate the need for CRCs and end this designation as the need for them subsides and residents within the CRCs are discharged to the appropriate setting.

CARE AND RECOVERY CENTER MINIMUM ELIGIBILITY CRITERIA

Before requesting to become a CRC, the nursing facility must determine its ability to meet the minimum participation requirements for designation. This includes the following:

- The facility has a rating of 3 or higher in the staffing category of the CMS Nursing Home Compart Five-Star Rating.
- The facility is not operating under a Denial of Payment for New Admissions (DPNA) restriction
- The facility is not designated by CMS in in Nursing Home Compare as a Red Hand Facility, indicating a citation for abuse.

CARE AND RECOVERY CENTER PARTICIPATION CRITERIA

MDHHS will collaborate with eligible nursing facilities to establish at least one CRC in each of the eight Emergency Preparedness Regions. MDHHS will select nursing facilities that meet the participation criteria and ask them to apply to become a CRC. MDHHS' approval of the CRCs includes input from Michigan's Department of Licensing and Regulatory Affairs (LARA) and the State Long-Term Care Ombudsman as it pertains to the standards below. MDHHS will review each application to assure that each nursing facility that applies to be a CRC meets the following standards:

PHYSICAL PLANT STANDARDS

1. CRCs must separate COVID-19-positive residents from COVID-19-negative or recovered COVID-19 positive residents.
2. An entire wing, unit, or separate building must be designated. Configurations with only certain rooms within a wing or unit will not be considered. Artificial walls or barriers must not be devised to form a separation of a wing or unit for the purpose of forming two distinct areas.
3. If a unit is designated, a separate entrance to and exit from the unit is required. This may include repurposing an emergency exit. Additionally, the designated wing is required to have its own staff entry, donning/doffing area, nursing station(s), supply rooms for linen storage (clean and soiled), medications, restrooms, and shower facilities for residents. Donning/doffing areas must have adequate supply available and trash receptacles to ensure proper waste management.
4. The bed space within the unit must be reserved for COVID-19-positive residents. This means not all beds may always be filled during the designation.

STAFFING STANDARDS

1. The CRC must designate staff to only work in the CRC area of the nursing facility.
2. The CRC's staffing plan must be based on appropriate nursing and Certified Nurse Aide (CNA) ratio for the bed capacity. The acuity of the resident's admitted in the CRC should also determine appropriate nursing/CNA to resident staffing ratios.

3. Daily staffing assignments must not allow workshare of CRC staff with another unit of the nursing facility.
4. CRC staff must have additional training on how to treat COVID-19-positive residents.
5. Staff must be aware of not only common COVID-19 symptoms of fever, cough or shortness of breath, but also additional symptoms that may be exhibited by residents including confusion, inability to arouse, or sore throat.
6. The CRC must have a qualified healthcare professional designated as the Infection Preventionist (IP) as validated by completion of the *CDC's Nursing Home Infection Preventionist Training Course*. Preferably the CRC's IP serves in the role and attends to the responsibility of the role full-time.
7. The CRC must have a return to work plan to replace workers who are unable to work because they have COVID-19 or are exhibiting symptoms of COVID-19.
8. The CRC must have a plan for use of emergency staffing resources (ie., staffing agency).

STAFFING RATIOS AND SUPPORTS

The CDC provides guidance for nursing facilities to address staffing shortages.

Many health care professionals have volunteered to assist in areas of need. CRCs may access this resource through the regional healthcare coalition.

CRC units and facilities must maintain staffing levels necessary to care for residents. The acuity of the resident's admitted in the CRC should also determine appropriate nursing/CNA to resident staffing ratios.

To the fullest extent possible, CRCs should maintain consistent staffing for early detection of changes in condition of residents. MDHHS requires CRCs to follow CDC guidance for return to work criteria for personnel confirmed or suspected of having COVID-19. To the extent possible, mitigation staffing strategies should employ training consistent with future assignments. CRCs must communicate any potential staffing crisis to ensure the needs of the residents are met.

INFECTION CONTROL STANDARDS

1. Each facility seeking designation must review their current infection control procedures. CRCs must follow CDC guidance for hand hygiene and infection prevention and control recommendations in healthcare settings as well as CMS detailed guidance for infection control and prevention in nursing homes.
2. Each facility seeking designation must have management policy and procedures that ensure staff compliance with infection control procedures including job specific infection control training for clinical and non-clinical staff.
3. The CRC should identify qualified clinical or non-clinical staff to serve as the facility's Infection Prevention Champion; completion of CDC training required.
4. The CRC must complete Environmental cleaning and disinfection of shared equipment, frequently touched surfaces in resident rooms and common areas, according to CDC guidance.

5. Upon resident discharge, resident rooms must be terminally cleaned before another resident is admitted to the room. Entry into these rooms for terminal cleaning or resident placement should be delayed long enough to allow for removal of potentially infectious particles.
6. Trash from the CRC may need to be collected more frequently and handled separately from other areas of the nursing facility.
7. Meal delivery to the residents of the CRC should be separate from the rest of the facility.

PERSONAL PROTECTIVE EQUIPTMENT

CRCs must communicate and coordinate with MDHHS on allocation of appropriate PPE for employees and residents (see reporting requirements below). MDHHS will monitor the PPE reported by each CRC to support PPE allocation and dissemination. When supplies are low within the CRC, the facility will be contacted to coordinate a shipment of needed PPE.

The CDC has developed a tool, PPE Burn Rate Calculator, to support healthcare facilities in planning and optimizing the use of PPE for the response to COVID-19.

The CRC is responsible for providing supplies necessary to maintain adequate hand hygiene practices (i.e. 60-95% based alcohol-based hand sanitizer, soap, and paper towels). Hand sanitizer must be available throughout the facility and staff are encouraged to have a personal hand sanitizing agent on their person as they work in the CRC.

Resources to support operations include the Centers for Medicare and Medicaid Services (CMS) COVID-19 Long-Term Care Facility Guidance (4.2.2020).

TESTING STANDARDS

1. The CRC must have a plan for complying with testing guidance from the CDC.
2. The CRC must employ and maintain resident and staff screening protocols, including accurate record of staff and residents tested and not tested. Records must detail a three-month history.

Refer to the MDHHS Skilled Nursing Facility Testing Guidance and Frequently Asked Questions (updated September 25, 2020) for guidance and information on COVID-19 testing of CRC staff and residents.

COMMUNICATION AND COORDINATION WITH OTHERS

1. Upon designation as a CRC, the CRC must notify the Local Health Department (LHD) and the Regional Health Care Coalition of this designation and remain in contact with the LHD regarding bed availability throughout its designation.
2. CRCs must track required data and report this information to MDHHS upon request and in accordance with any MDHHS guidance.
3. CRCs must determine how they plan to communicate with the family, friends, and legal guardians of COVID-19-positive residents. The use of virtual visitation is strongly encouraged to support communication with family and friends.

4. Admissions to and discharges from the CRC must be reported to other payers such as Medicare, Medicaid, and other insurers.
5. For Medicaid-eligible residents, admissions to and discharges from the CRC must be reported to other programs including Medicaid Managed Care Plans, PACE organizations, MI Health Link Integrated Care Organizations, MI Choice, and the resident's original nursing facility or other long-term care facility.
6. CRCs must have a relationship with the local Long-Term Care Ombudsman and work closely with them during this emergency. Best practice is to contact the local Long-Term Care Ombudsman to let them know about transfers into and out of the CRC. The Ombudsman can address many concerns of the residents and families.
7. CRCs must adhere to current care coordination requirements for residents receiving hospice services.

PANDEMIC PERFORMANCE STANDARDS

Nursing facilities will also be evaluated by the following factors prior to receiving designation as a Care and Recovery Center:

1. Death-to-case ratio during the COVID-19 pandemic
2. Outbreak history in the facility
3. LARA survey history

CARE AND RECOVERY CENTER ADMISSIONS

MDHHS designated CRCs are required to accept referrals and admit COVID-19-positive patients discharging from a hospital and other nursing facilities that are unable to properly isolate residents with confirmed COVID-19 who have not met criteria for discontinuation of Transmission-Based Precautions. The referring hospital or long-term care facility must provide adequate medical history and relevant clinical information to support the transition.

HOSPITAL REFERRAL

The preference is for confirmed COVID-19 positive hospital patients to remain in the hospital if the patient has less than 72 hours remaining in their overall isolation period. Confirmed COVID-19-positive hospital patients who require additional care and support may be discharged to a CRC. Patients admitted directly from the hospital do not need to meet MDHHS Nursing Facility Level of Care.

In circumstances when a COVID-19-positive individual meets Medicaid Nursing Facility level of care, MDHHS will consider CRC admissions from other long-term care facilities, assisted living facilities, homes for the aged, and adult foster care homes on a case-by-case basis.

The CRC should ensure the transferring facility completes the Nursing Facility Surveillance Form to support care coordination during transitions.

LEVEL OF CARE

The level of care required for admission following a hospital discharge or facility of residence transfer to a CRC is restricted to COVID-19-positive residents who have a need for medical care or additional support not otherwise available. Nursing facilities designated as a CRC must provide the level of care and support required by the residents' plan of care.

The CRC may submit Medicaid claims for a resident's care if the resident has a current Nursing Facility Level of Care Determination (LOCD) in CHAMPS. The admission requirements are not meant to circumvent applicable Medicaid payment requirements.

ADMISSION PROTOCOL

To transfer a resident to a CRC, a local hospital or nursing facility must contact the CRC regarding the resident and their specific needs. There is no direct admission to the CRC. All patients must come through a hospital or nursing facility. To support a smooth transition, MDHHS requires:

1. Case managers or discharge planners to make initial contact to discuss the appropriateness of each resident for the CRC.
2. The transferring facility to follow their normal process for arranging interfacility transfer to the CRC.
3. The resident's advanced directive including any Do Not Resuscitate (DNR) provision must accompany the resident at the time of the transfer and be disclosed to Emergency Medical Services (EMS) when requesting a transfer.

The transferring facility is responsible for the coordination and covering the cost of transporting the resident to the CRC or other setting. Before transport, the transferring facility must assure the resident's belongings and equipment are properly labeled or stored. All necessary documentation related to the resident's care must be complete and accompany the resident.

When capacity within the CRC allows, the facility must accept the admission of the resident according to the scenarios described below.

RESIDENT BELONGINGS

The referring entity is responsible for labeling and securely storing the resident's belongings that do not accompany the resident to the CRC.

When transferring from either a nursing facility or other long-term care facility, the facility of residence should discus temporarily transferring the residents' personal funds to the resident's guardian, or another person of the residents' choice.

RESIDENT EQUIPMENT

In a transfer from the resident's long-term care facility, resident-specific and necessary durable medical equipment (DME) such as, but not limited to enteral feeding pump, intravenous infusion device, oxygen equipment and supplies, communication devices and other assistive technology, and motorized wheelchairs must be labeled and accompany the resident, unless the items are provided by the CRC.

The resident's transferring long-term care facility and CRC are responsible for tracking any inventory and ensuring the return of any DME, which shall be returned to the facility of origin after being disinfected, in like condition as soon as possible. The CRC is responsible for appropriately tracking the use and necessary maintenance of all resident specific DME and supplies during the time such items are in the custody of the CRC.

CARE AND RECOVERY CENTER SERVICES AND SUPPORTS

TELECOMMUNICATIONS

The CRC must facilitate the use of telemedicine to the extent feasible for, but not limited to, regular doctors' visits, telepsychology, counseling, social work, and other behavioral health visits and physical an occupational therapy.

Additional efforts should be made to facilitate communication between the resident and family members or others using telephones, tablets, and other devices.

TRANSFER TRAUMA

Operating during the coronavirus pandemic is stressful for healthcare providers and residents. The risk of residents experiencing transfer trauma are increased at this time. Transfer Trauma refers to the various mood, behavioral, and physiological symptoms that may occur when a resident is transferred. CRCs are encouraged to monitor residents for transfer trauma symptoms and make every effort to mitigate the effects.

POPULATION MANAGEMENT

CRCs must review their population management activities with respect to the facility's capacity, resident placement, and the residents' plan of care. The CRC's capacity may be affected by its ability to cohort according to the resident and the resident's symptomology. CRCs must consider the resident's medical needs, such as residents requiring care that may increase secondary spread via aerosol-generating procedures (e.g. respiratory treatments).

CRCs must conduct regular population management activities including symptom monitoring and tracking. MDHHS has provided a Resident Surveillance Form to aid in this process.

MDHHS reserves the right to update reporting requirements as needed.

TRANSMISSION-BASED PRECAUTIONS

All CRCs must follow CDC guidance on Transmission Based Precautions and when these can be discontinued.

- Visitors and patients should wear cloth face coverings, facemasks should be reserved for healthcare professionals.
- Actively screen everyone for fever and symptoms of COVID-19 before they enter the CRC.

- As community transmission intensifies within a region, CRCs should consider foregoing contact tracing for exposures within the setting in favor of universal source control for healthcare professionals and screening for fever and symptoms before every shift.

Key concepts in the Transmission Based Precautions guidance:

- **Reduce facility risk**. Cancel elective procedures, use telemedicine when possible, limit points of entry and manage visitors, screen everyone entering the facility for COVID-19 symptoms, implement source control for everyone entering the facility, regardless of symptoms.
- **Isolate symptomatic patients as soon as possible**. Set up separate, well-ventilated triage areas, place patients with suspected or confirmed COVID-19 in private rooms with the door closed and with private bathrooms (as possible). Reserve AIIRs for patients with COVID-19 undergoing aerosol generating procedures and for care of patients with other pathogens transmitted by the airborne route (e.g., tuberculosis, measles, varicella).
- **Protect healthcare personnel**. Emphasize hand hygiene, install barriers to limit contact with patients at triage, cohort patients with COVID-19, limit the numbers of staff providing their care, prioritize respirators for aerosol generating procedures.

CARE AND RECOVERY CENTER DISCHARGE

Residents may be discharged from a CRC under the following conditions:

- The resident has been isolated with precautions for 10 days after symptom onset and resolution of fever for at least 24 hours, without the use of fever-reducing medications, and with improvement of other symptoms.
- The resident never developed symptoms and was isolated with other precautions for 10 days after the date of their first positive RT-PCR test for SARS-CoV-2 RNA.
- The resident chooses to discharge to a private home or their nursing facility of residence if that facility can provide proper isolation.

All CRC discharges must have a safe and appropriate discharge plan in place.

DISCHARGE PROTOCOL

The CRC must notify the resident, family, and the resident's legal representative of any planned transition as soon as possible. Communication to the resident, family and guardians must include the MDHHS letter addressing transfers provided in Appendix D: Resident Transfer Notice.

If the resident is discharged to a long-term care setting the CRC must provide the receiving facility with documentation of the resident's COVID-19 status, the assessment, care plan, physician orders, and contact information for family and the resident's legal representative.

The CRC must send with the resident all personal belongings, including glasses, dentures, hearing aids, and other personal possessions.

The resident's advanced directive including any Do Not Resuscitate (DNR) provision must accompany the resident at the time of the transition and be disclosed to EMS when requesting a transfer.

MDHHS has developed a checklist to facilitate resident transfer preparations. See Appendix C: Nursing Facility Resident Transfer Checklist

RETURNING TO A LONG-TERM CARE SETTING

When the CRC can verify that the resident has met the criteria for discharge from the CRC, the facility of residence must accept the return of the resident. If the facility of residence does not have an available bed, the resident must be discharged to the next available bed.

RETURNING TO THE GENERAL POPULATION

If the CRC is operating as a wing, unit, or separate building of a facility that continues to serve a general population and made an internal transfer of a resident from its general population to the CRC unit, it shall transfer the resident back to its general population after discharge criteria is met.

RETURNING TO THE RESIDENT'S HOME

Some residents may choose to return to their home or a family member's home during the coronavirus crisis. The CRC must consult with the LHD during the initial stages of discharge planning. The CRC and other nursing facilities should confirm that the resident will receive the necessary care from the family or community-based services, as well as access to a community physician for treatment and prescriptions. Caregiver training and resource materials should be provided, if needed.

DECEASED COVID-19-POSITIVE RESIDENTS

CRCs must communicate the death of the COVID-19-positive resident to the LHD, facility of residence, family, the resident's legal representative and hospice as applicable. CRCs also must follow their current procedures regarding postmortem care and removal of the deceased from the facility. The LHD will advise the CRC whether postmortem testing should be pursued.

Unless provided by the CRC, the facility is responsible for disinfecting and coordinating the return of any DME to the facility of origin as soon as possible.

The CRC must also ensure all the residents' personal items are secured and labeled and afford the resident's family or legal representative an opportunity to retrieve the residents' personal belongings.

To reduce the risk of transmission, following the removal of the deceased resident, the CRC must ensure the room is terminally cleaned before the admission of a resident to the room.

ADMINISTRATIVE FUNCTIONS

MDHHS and LARA will closely monitor the CRC activities, including on-site consultation and weekly monitoring calls for continued compliance with CRC requirements.

CARE COORDINATION

RESIDENTS WITH END-STAGE RENAL DISEASE

CRCs must have a plan to ensure residents with End-Stage Renal Disease (ESRD) receive scheduled dialysis treatments. In response to the health crisis, CMS is allowing dialysis services in the nursing facility. CRCs are advised to ensure dialysis services are provided in the nursing facility to reduce community spread of COVID-19. For dialysis services not immediately available in the facility, CRCs must notify the outpatient dialysis facility of the resident's condition prior to transport for receipt of dialysis services. It is expected the outpatient dialysis facility will adhere to CDC's Interim Additional Guidance for Infection Prevention and Control Recommendations for Patient with Suspected or Confirmed COVID-19 in Outpatient Hemodialysis Facilities.

RESIDENTS RECEIVING HOSPICE SERVICES

CRCs are encouraged to support end of life situations. The CRC and the resident's hospice team should discuss available options to ensure the goals and wishes of the resident. MDHHS encourages using telehealth visits with hospice providers and virtual communication with families to the extent possible. Due to risk of transmission imposed to the hospice resident's family, CMS recommends restricting in-person hospice visitations. Alternative methods may be employed to provide closure for imminent end of life situations for hospice residents, as well as those not receiving hospice services.

RESIDENTS AND FAMILIES

At admission, the CRC must contact the resident's family and legal representative and provide contact information for the CRC. Prior to transfer from the CRC, the staff must notify the resident, family, and the resident's legal representative of the planned transfer as soon as possible. Communication to the resident, family and the resident's legal representative must include the MDHHS letter addressing transfers provided in Appendix D: Resident Transfer Notice.

During the resident's stay at the CRC, staff must facilitate communication between the resident and the resident's family to the extent feasible.

MICHIGAN LONG-TERM CARE OMBUDSMAN

CRCs must notify the Long-Term Care Ombudsman of all residents transferred including the name of resident and resident's representatives, and contact information (phone or email) for each.

PAYERS AND PROGRAMS

CRCs must notify and coordinate with applicable Medicaid Managed Care Organizations when members are admitted to the CRC. This includes:

- Medicaid Health Plans (MHPs)
- Integrated Care Organizations (ICOs)
- PACE Organizations
- MI Choice Waiver Agencies
- Pre-paid Inpatient Health Plans (PIHPs)

Upon designation and execution of the Conditions of Participation letter, the CRC should have received contacts for the above payers and programs to support coordination efforts.

REPORTING REQUIREMENTS

GENERAL REQUIREMENTS

CRCs must comply with all state and federal reporting requirements. Guidance on additional state-specific reporting requirements will be provided to facilities who are designated as CRCs. CRCs must report all data requested by MDHHS at the cadence established in this guidance.

CRISIS AVOIDANCE

The COVID-19 CRC must contact MDHHS and the LARA if the CRC is unable to follow this guidance because of staff shortages, PPE shortages, or other reasons. CRCs can contact MDHHS with these or any other concerns via email at MDHHS-CareAndRecoveryCenters@michigan.gov.

COST REPORTING & AUDIT

Guidance on cost-reporting will be provided to facilities who are designated as CRCs. CRCs must account for expenditures associated with COVID-19 and be prepared to provide support for these expenditures. These expenditures may be subject to audit.

CARE AND RECOVERY CENTER BED-CAPACITY CHANGES

MDHHS may reduce or increase the CRC bed-capacity or deactivate a CRC when additional beds are needed or full capacity is no longer required. To maintain the safety of all residents and support resident choice, MDHHS will provide advance notification of intent to reduce capacity or deactivate a CRC. The purpose is to ensure the safe transfer or discharge of remaining residents and support the CRC's transition. Upon receipt of an advance notification, the CRC must respond with their plan within 10 business days as described below.

Other instances that may require MDHHS to deactivate a CRC are as follows:

- The Care and Recovery Center meets one of the exclusion criteria.
- The Care and Recovery Center fails to meet the operational criteria.

In these instances, MDHHS will conduct an in-depth review on a case-by-case basis. Approval or denial notification of changes in bed-capacity or deactivation will be forwarded directly to the CRC. Determinations made by MDHHS are deemed final.

BED-CAPACITY REDUCTION PROCESS

Upon notification from MDHHS or if the CRC chooses to reduce bed-capacity on its own, the CRC must submit a revised bed-capacity plan to MDHHS for approval.

The plan to reduce capacity must include:

- The nursing facility's revised floor plan for the designated CRC
- An explanation of how residents in the beds planned for reduction will be safely relocated
- Decontamination strategy for the beds being removed from the CRC that delineates infection control procedures to be used before use for non-COVID-19-affected residents in these rooms/unit(s)
- The requested effective date of the reduction
- The requested revised number of beds to remain for COVID-19-positive residents

BED-CAPACITY RESUMPTION/INCREASE PROCESS

MDHHS may require a CRC to increase their bed-capacity. The process for increasing the bed-capacity will be determined based on:

- Previous MDHHS notification or CRC request to reduce bed-capacity, or
- Current CRC Center bed-capacity has been exceeded

The plan to resume or increase current capacity must include:

- A revised floor plan clearly indicating the resumption of previously approved bed or additional beds for the CRC,
- An explanation of how the resumption or expansion of the designated wing/unit will impact non-COVID-19-affected residents and the plan for their safe transfer to a non-CRC unit
- An explanation of how residents in the CRC rooms/units will be impacted by increased bed-capacity

- The requested effective date of the CRC expansion
- The requested revised number of beds for COVID-19-positive residents

CARE AND RECOVERY CENTER DEACTIVATION PROCESS

Upon notification from MDHHS or if the CRC chooses to deactivate the CRC status, the CRC must include a written plan for the relocation of any remaining residents in the CRC.

The plan must address the following:

- Scheduled discharge dates for each resident of the CRC, along with anticipated place for discharge.
- Decontamination strategy for the CRC that delineates infection control procedures to be used for putting non-COVID-19-positive residents in the rooms once used as a CRC.
- The requested effective date to deactivate the CRC.

Upon submission of the request to reduce capacity or deactivate, MDHHS will review submitted materials. Following review, the CRC may be required to modify the plan to ensure the health and welfare of residents not only within the CRC, but also the rest of the nursing facility and the community.

APPENDICES

MDHHS has developed work aids to support the efforts of the CRC which are located in the following appendices

APPENDIX A: GLOSSARY

Adult foster care facility has the same meaning provided by section 3(4) of the Adult Foster Care Facility Licensing Act, MCL 400.703(4).

Alternate care facility means any facility activated by the state to provide relief for hospitals that surge past their capacity, including but not limited to the TCF Regional Care Center.

Appropriate Personal Protective Equipment (PPE) means a facemask, a form of eye protection including goggles or a face shield, gloves, and a gown. In the event that an aerosol generating procedure is used, then appropriate PPE also includes a N-95 mask. This definition is subject to any changes in MDHHS guidance.

Assisted living facility means an unlicensed establishment that offers community-based residential care for at least three unrelated adults who are either over the age of 65 or need assistance with activities of daily living (ADLs), including personal, supportive, and intermittent health-related services available 24-hours a day.

COVID-19-affected resident means a resident of a long-term care facility who is COVID-19 positive, who is a person under investigation, or who displays one or more of the principal symptoms of COVID-19.

COVID-19-positive resident means a resident of a nursing facility or other long-term care facility who is confirmed by test positive for COVID-19.

Care and Recovery Center: means a nursing facility that is designated by MDHHS to temporarily and exclusively provide care for and isolate COVID-19-affected residents. A CRC also includes a nursing home that was previously designated as a regional hub by MDHHS, until such time as the facility's regional hub designation is rescinded. A CRC must accept COVID-19-affected resident in accordance with relevant MDHHS orders and guidance.

Home for the aged: has the same meaning provided by section 20106(3) of the Public Health Code, MCL 333.20106(3).

Long-term care facility: Nursing homes, homes for the aged, adult foster care facilities and unlicensed assisted living facilities.

Medically unstable means a change in mental status or a significant change or abnormality in blood pressure, heart rate, oxygenation status, or laboratory results that warrants emergent medical evaluation.

Person under investigation: or "PUI" means a person who is currently under investigation for having the virus that causes COVID-19.

APPENDIX B: NURSING FACILITY RESIDENT SURVEILLANCE FORM

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NURSING FACILITY RESIDENT SURVEILLANCE FORM

Full assessment of the resident must be completed at minimum once a shift. In the event transfer is required to another facility or hospital, the resident's Nursing Facility Resident Surveillance Form must accompany the resident. For accurate monitoring, the receiving facility should continue documenting on the form received from the transferring facility. It is advised the originating nursing facility to retain a copy of the resident's surveillance form for their records.

Resident Name:_____ **DOB (MM/DD/YYYY):** _____

Nursing Facility: _____

Symptom Start Date: _____ **14-Day Quarantine START date:** _____

Symptom End Date: _____ **14-Day Quarantine STOP date:** _____

DATE	TIME	VITALS					SIGNS & SYMPTOMS						DIAGNOSTICS				
		Heart Rate	Blood Pressure	Respiratory Rate	Pulse OX	Glucose (required for diabetics)	Fever (Y/N)	Cough (Y/N)	Myalgia (Body Ache) (Y/N)	Sore Throat (Y/N)	Diarrhea (Y/N)	Tiredness or Fatigue (Y/N)	Date of Chest X-Ray (MM/DD/YYYY)	COVID-19 Test Performed (Y/N)	Date of COVID-19 Test Results (MM/DD/YYYY)	COVID-19 Test Results (+) Positive; (-) Negative	If test is inconclusive, date of COVID-19 re-testing ((M/DD/YYYY)

Resident Name: _____ **DOB (MM/DD/YYYY):** _____

DATE	TIME	VITALS					SIGNS & SYMPTOMS						DIAGNOSTICS				
		Heart Rate	Blood Pressure	Respiratory Rate	Pulse OX	Glucose (required for diabetics)	Fever (Y/N)	Cough (Y/N)	Myalgia (Body Ache) (Y/N)	Sore Throat (Y/N)	Diarrhea (Y/N)	Tiredness or Fatigue (Y/N)	Date of Chest X-Ray (MM/DD/YYYY)	COVID-19 Test Performed (Y/N)	Date of COVID-19 Test Results (MM/DD/YYYY)	COVID-19 Test Results (+) Positive; (-)	If test is inconclusive, date of COVID-19 re-testing

APPENDIX C: NURSING FACILITY RESIDENT TRANSFER CHECKLIST

Resident Name: _____ DOB: _____

Discharging Facility: _____

All items must accompany the resident at the time of transfer.

- ☐ Face Sheet
- ☐ Advance Directives - Do Not Resuscitate (DNR) orders are to remain in place
- ☐ Detailed Order Summary
- ☐ Physician Order to Discharge
- ☐ Care Plan Summary
- ☐ Vital Signs Summary (last 14 days), include any relevant COVID-19 assessment tools
  - Nursing Facility Resident Surveillance Form
- ☐ Most Recent History & Physical
- ☐ 3-Days of Nursing Notes including Change of Condition (i.e. SBAR: Situation, Background, Assessment & Recommendation)
- ☐ Most Recent Social Worker Notes
- ☐ Most Recent Chest X-Ray & Lab Results
- ☐ Non-controlled Medications (i.e. oral, liquid, ophthalmic, respiratory, and wound care)
- ☐ Controlled (Schedule II – V) Medications
- ☐ Intravenous Therapy
  - If the resident is currently receiving intravenous therapy, all IV medications, IV pump and other pharmacy delivered items (i.e., IV tubing, saline syringes, etc.)
- ☐ Resident Inventory Sheet (i.e. personal items including Hoyer lift pads, etc.)
- ☐ Most Recent Minimum Data Set (MDS) Review

Hospice Residents

- ☐ Hospice Agency, including contact information
- ☐ Hospice orders, and all relevant information

Resident's with End-Stage Renal Disease

For resident's receiving off-site dialysis services:

- ☐ Scheduled Hemodialysis Appointment Times
- ☐ Hemodialysis Provider and Location (i.e. address, phone number)
- ☐ NEMT Information (i.e. address, phone number)

For resident's receiving on-site dialysis services:

- ☐ Hemodialysis Provider, including contact information

To support the identification of the resident's belongings during the transfer process, the nursing facility should ensure the resident's belongings are clearly marked for with the resident's first and last name. This includes, and not limited to clothing, medications, and equipment used to support the resident's care.

Lastly, the resident, family or legal representative should be made aware of the transfer prior to or at the earliest available time.

APPENDIX D: RESIDENT TRANSFER NOTICE

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APPENDIX E: REGIONAL HEALTHCARE COALITION CONTACT INFORMATION

Michigan Emergency Preparedness Regions Map

Region 1
2123 University Park Drive, Suite 110
Okemos, MI 48864
Office: 517-324-4404
Fax: 517-324-4406
Email: d1rmrc-matt@sbcglobal.net
www.d1rmrc.org

Region 2
6754 Brandt Street
Romulus, MI 48174
Office: 734-728-7674
Fax: 734-902-6000
Email: AShehu@2South.Org
portal.2south.org

Region 5
1000 Oakland Drive
Kalamazoo, MI 49008
Office: 269-337-4286
Fax: 269-337-6475
Email: Richard.Winters@med.wmich.edu
www.5dmrc.org

Region 7
80 Livingston Boulevard, Suite 106
Gaylord, MI 49735
Office: 989-748-4975
Fax: 989-748-4980
Email: rc@mir7hcc.com
www.Miregion7.com

Region 2N
705 Barclay Circle, Suite 140
Rochester Hills, MI 48307
Office: 248-759-4748
Fax: 248-759-4751
Email: rdrummer@region2north.com
www.region2north.com

Region 3
1575 Concentric Boulevard
Saginaw, MI 48604
Office: 989-746-7757
Fax: 989-746-7767
Email: rob.kelly@cmich.edu
www.Region3HCC.org

Region 6
1675 Leahy Street, Suite 308B
Muskegon, MI 49442
Office: 231-728-1967
Fax: 231-728-1644
Email: Laurner@wmrmc.org
www.miregion6.org

Region 8
1202 Wright Street, Suite E
Marquette, MI 49855
Office: 906-273-2125
Fax: 906-273-2126
Email: ed.unger@region8.org
www.region8.org

MICHIGAN COUNTIES BY REGION

Region	Counties	
1	Lenawee Hillsdale Livingston Jackson Gratiot	Clinton Ingham Eaton Shiawassee
2N	Oakland St. Clair	Macomb
2S	Wayne Monroe	Washtenaw
3	Genesee Bay Huron Lapeer Arenac Iosco Ogemaw	Sanilac Tuscola Saginaw Midland Gladwin Oscoda Alcona
5	Barry Allegan Van Buren St. Joseph Branch	Kalamazoo Calhoun Berrien Cass
6	Isabella Oceana Newaygo Muskegon Ottawa Kent Ionia	Clare Osceola Mecosta Lake Mason Montcalm
7	Grand Traverse Wexford Leelanau Emmett Charlevoix Roscommon Presque Isle Montmorency Alpena	Antrim Kalkaska Benzie Manistee Missaukee Cheboygan Otsego Crawford
8	Marquette Chippewa Mackinac Luce Schoolcraft Alger Delta Gogebic	Menominee Dickinson Iron Baraga Keweenaw Houghton Ontonagon

APPENDIX F: REVISION HISTORY

Revision Date	Version	Section(s)	Page(s)	Summary
10/6/2020	2	All	All	Updated previous COVID-19 Regional Hub policy to be consistent with the switch to Care and Recovery Centers.