CHRT

Keeping nursing home residents safe and advancing health in light of COVID-19

ANALYSIS AND RECOMMENDATIONS FOR THE STATE OF MICHIGAN

DECEMBER 3, 2020

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About CHRT

CHRT is an independent nonprofit at the University of Michigan that works to inspire and enable evidence-informed policies and practices that improve the health of people and communities. Learn more about CHRT at chrt.org.

About the funder

This study was supported by the Michigan Health Endowment Fund, which works to improve the health and wellness of Michigan residents and to reduce the cost of healthcare, with a special focus on children and seniors. Learn more about the Health Fund at mihealthfund.org.

# Background on COVID-19 in Michigan nursing homes

Introduction

As of August 28, 2020, 5.8 million Americans had been infected with COVID-19—1,784 cases per 100,000 people—and more than 180,000 Americans had died. COVID-19 has disproportionately affected nursing home residents in the U.S. and in Michigan since the first reported U.S. death in February 2020.

Nationally, reported nursing home resident COVID-19 deaths represented 38.6 percent of all COVID-19 deaths as of August 20, 2020.[1] On average in Michigan, between March and August 2020, nursing home residents fared better than in many other states. In that period, confirmed nursing home resident COVID-19 deaths represented 33.0 percent of Michigan's total COVID-19 deaths (Figure 1).

Figure 1

Michigan nursing home residents constituted a smaller proportion of overall COVID-19 deaths than the U.S. national average. *(Cumulative through August 19-20, 2020)*
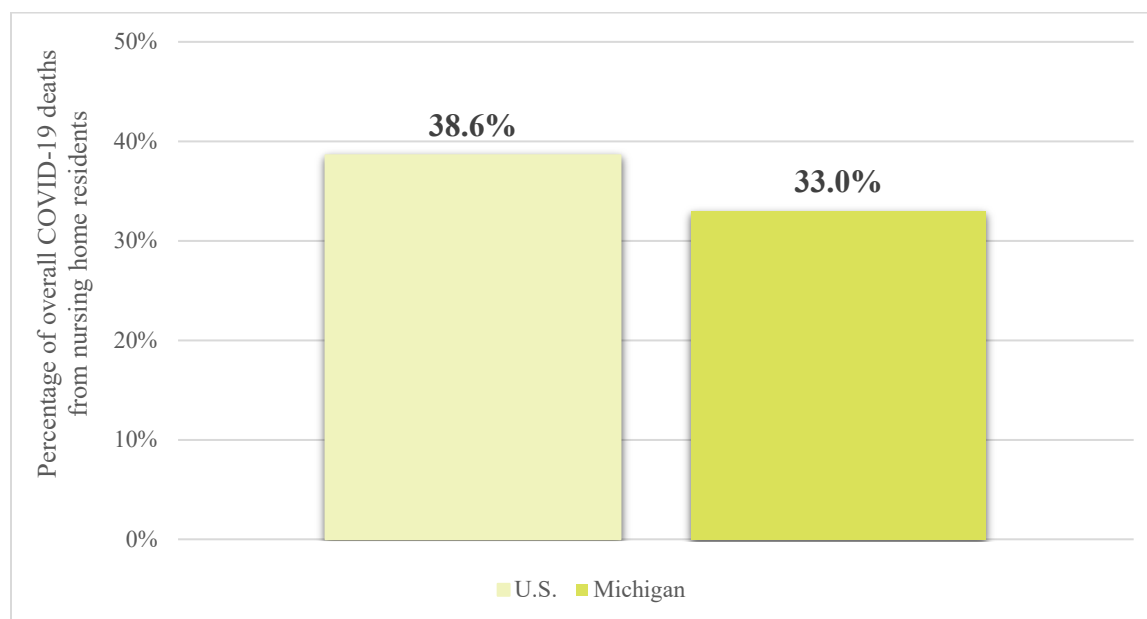
This report provides a high-level evaluation of Michigan's regional hub strategy and recommendations for moving forward, given that there is no immediate predicted end to the pandemic.

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[1] Updated with data from Michigan's statewide long-term care COVID-19 report, the Kaiser Family Foundation Report, the COVID Tracking Project, and the CDC. National data reflects a period of March – August 20, 2020. Michigan-only data reflects a period of March – August 19, 2020. For national data, reporting on COVID-19 cases and deaths among residents is often done in the context of "long-term care (LTC) facilities." As long-term care facility is an umbrella term for various types of care facilities, these reports may include data from nursing homes, assisted living facilities, or other uncategorized LTC facilities. Publicly available data sources often combine both staff and resident cases and deaths in aggregate LTC totals. For this report, CHRT adjusted national LTC COVID-19 data to isolate COVID-19 cases and deaths for nursing home residents only. For states with missing data, resident cases and deaths were supplemented with CMS data to enable the inclusion of all 50 states and Washington D.C.

Study approach

CHRT employed a data-driven, evidence-based strategy to both evaluate Michigan's regional nursing home hub strategy and to make recommendations for future approaches in light of COVID-19[2]:

- Twenty-eight structured interviews—with national policy experts, state administrators, nursing home leaders, and hospital and other clinical leaders—to identify best practices;

- A comprehensive literature review to understand what peer-reviewed research to date says about the effectiveness of these and other practices;

- An analysis of Michigan data provided by the state including data reported by nursing homes on resident and staff COVID-19 cases and deaths;

- An analysis of national data from a variety of sources to correct for reporting differences and to enhance the comparability of Michigan and national data sets.

Key findings

Michigan's response to long-term care COVID-19 cases

Different regions of the country experienced peak outbreaks at various times since the first COVID-19 cases were confirmed in the U.S. Michigan's first confirmed case of COVID-19 was on March 10, 2020. Michigan cases peaked on March 30, 2020. (Figure 2)

Figure 2

Michigan cases peaked on March 30, 2020. *(Reported cases are from March 1 – August 31, 2020.)*
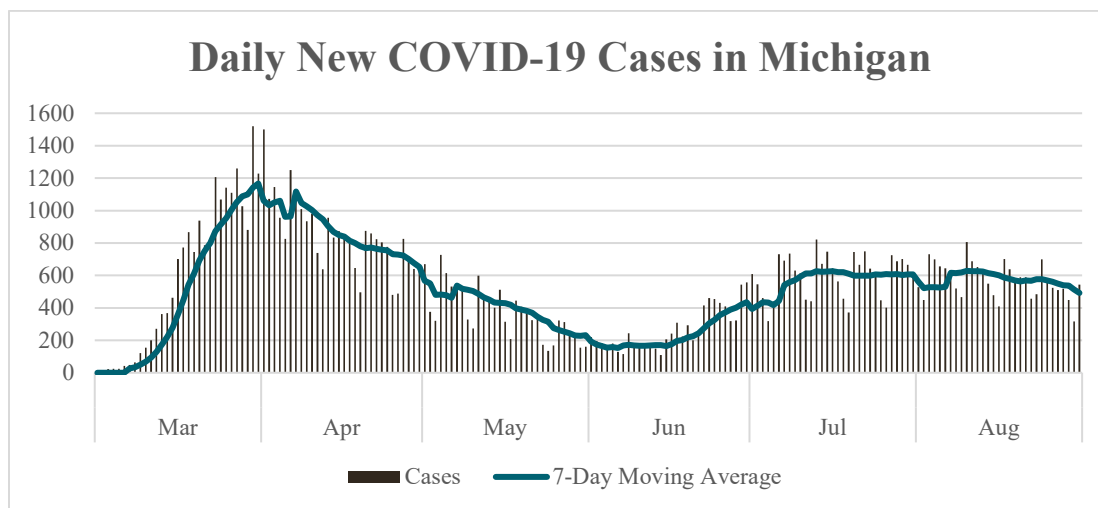
Since the beginning of the outbreak, Michigan has enacted a number of policies and issued various guidance for nursing homes to keep residents and staff safe. (Figure 3)

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[2] Additional detail on data analyses, literature review, interview summaries, and recommendation implementation is included in appendices.

Figure 3

Michigan's COVID-19 response: Key policies for long-term care

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March 14, 2020

- Michigan issued an emergency order to restrict visitation in nursing homes.

April 15, 2020

- Michigan established regional hubs.
- Michigan issued an executive order (EO 2020-50) with a number of protocols to enhance protections for residents and staff of long-term care facilities. This executive order included the following:

    - Restrictions on communal dining and internal and external group activities;

    - Enhanced transfer and discharge procedures;

    - Requirements on reporting on PPE stock and COVID-19 cases in nursing homes;

    - Requirements regarding admission and readmissions: "Facilities must not prohibit admission or readmission of a resident based on COVID-19 testing requirements or results in a manner that is inconsistent with relevant guidance issued by MDHHS;"

    - Facilities must use best efforts to facilitate the use of telemedicine, including for telepsychology visits.

June 15, 2020

- Michigan extended protections noted in EO 2020-50, and subsequent executive orders.

June 26, 2020

- Michigan established the Nursing Home COVID-19 Preparedness Task Force with a charge of informing the state's response to a potential second wave of COVID-19.
- Michigan extended visitation restrictions and provided that the director of MDHHS may specify exceptions to the order.

June 30, 2020

- MDHHS issued emergency order allowing visitation in limited cases of assistance with activities of daily living (ADLs) and end of life.

August 28, 2020

- Executive order 2020-174 further extended visitation restrictions through September 30, 2020.

September 5, 2020

- Executive order 2020-179 further extended enhanced protections for residents and staff of long-term care facilities through September 30, 2020.

Other state approaches to long-term care COVID-19 cases

Early on, when the COVID-19 pandemic first hit the state of Washington in February 2020, it became apparent that nursing homes were particularly vulnerable to outbreaks. However, there were very few guideposts on how to keep residents safe in nursing homes. As a result, as COVID-19 moved across the country, states employed many different tactics to try to keep nursing home residents safe, learning from each other in real time. (Figure 4)

Figure 4

Key examples of the variability of state responses

Arkansas: The Arkansas Health Care Association, the state's largest organization of long-term care providers, played an important role in coordinating information for nursing homes and sharing simplified guidance through weekly webinars about new guidelines and regulations with time for questions.

Florida: The state of Florida implemented COVID-19-only facilities early on, but is now transitioning to mostly wings or units within nursing homes, similar to Michigan's hub approach. The main reason for the state's initial COVID-19-only approach was opportunistic: brand new facilities were available that were not yet occupied. This initial approach has not been continued in Florida because of the need for more accessible facilities, less arduous transfer processes, and the significant cost burden of maintaining these facilities.

Maryland: As of July 15, 2020, Maryland was one of seven states to require ongoing testing of residents, staff, or both. Maryland provides universal testing at no cost to nursing homes to facilitate this requirement.

Massachusetts: Massachusetts developed an assessment tool in partnership with a consulting firm to assess each nursing home in the state. The assessment determined nursing home needs regarding infection control practices, staffing, personal protective equipment (PPE), and other policies.

New York: LeadingAge New York developed guidance for nursing homes on infection control and created a supplemental tool to help nursing homes prepare for COVID-19. Key information for nursing homes is available on a centralized website, including resources on funds for communication devices for residents, sample fact sheets on visitation, and infection control protocols.

Structural approaches

States have used various structural approaches to isolate COVID-positive residents, including freestanding facilities and separate floors or units/wings within an existing nursing home. However, most states have moved away from using separate facilities due to cost and access issues.

Over time, global and U.S. states' experiences with COVID-19 in nursing homes showed that residents could be maintained safely within nursing homes with adequate personal protective equipment (PPE), staffing, cohorting, and infection control protocols.

Doctors without Borders (Médecins Sans Frontières, or MSF) spent two months in Michigan in May and June 2020 helping nursing homes and assisted living facilities in Detroit. MSF left effective tools and provided rich global experience to inform best practices.

MSF emphasized that a "one size fits all" approach cannot be applied when determining whether or not nursing homes can house residents safely. Some nursing homes are better equipped to cohort their residents within the facility, while others do not have the capacity or facility design to care for COVID-19 residents safely and would need to transfer residents to another facility.

Guidance and training

Throughout the COVID-19 pandemic, guidance on infection control, proper use of PPE, visitation, and other policies changed frequently. Nursing homes were inundated with federal, state, and local requirements that sometimes conflicted. Local public health departments were also not always apprised or aware of changing guidance and at times, provided with conflicting or varied information.

Even when guidance was clear, MSF found that many nursing homes did not always know how to apply the guidance they received. For example, some nursing homes went beyond regulations or guidance by requiring all staff to wear gowns in administrative areas of the building and to double gown when entering a resident's room whereas others misunderstood when extended wear of PPE was acceptable and when it was not. MSF found that on-site training was necessary to augment written guidance.

Finally, historical regulatory approaches to nursing home safety oversight and organizational cultures have contributed to challenges in implementing best practices. Regulators have often taken a punitive rather than a teaching approach when identifying safety concerns, and some organizational cultures have discouraged reporting problems for fear of sanctions. A culture of fear within nursing homes has led to a lack of willingness to speak up when problems are identified. Additionally, many nursing homes lack access to ongoing training on changing best practices.

Successful training models require on-site technical assistance. MSF developed a model training program for nursing schools that it provided to Wayne State University and University of Detroit Mercy. National and local hospitals have also partnered with nursing homes to provide training and tools. Michigan's Infection Prevention Resource and Assessment Team (IPRAT) provides training to local health departments. And the U.S. Department of Health and Human Services' Quality Improvement Organizations—in Michigan, the Michigan Peer Review Organization (part of the Superior Health Quality Alliance)—is also required to provide training to nursing homes related to COVID-19.

Personal protective equipment

Interviews with key experts and national research emphasized the importance of having a substantial supply of PPE supplies in preparation for unanticipated surges in COVID-19 cases.

Advance planning, so that supplies are available when needed, is a best practice to manage potential PPE shortages. Nursing homes that did advance planning were better prepared to handle the surge in cases and had better outcomes overall.

The ability to share PPE across corporate entities and among regions in need was also identified as a best practice. Nursing home interviewees indicated that PPE shortages are still a challenge throughout the U.S., particularly related to gowns.

Nursing homes with less than a one week supply of PPE are typically considered to have a PPE shortage.[i] CMS data for Michigan showed that approximately 46 percent of nursing homes had some sort of PPE shortage at some point between the end of May and the beginning of August 2020.

In the week ending July 12, 21 percent of facilities reported shortages, which increased to 27 percent of facilities by August 2, 2020. The shortages varied across the state, with some regions reporting no shortages, while others had high proportions of facilities that reported PPE shortages.

The variability in need and access to PPE speaks to the importance of an accurate data tracking system and the potential value of a shared distribution system across nursing homes throughout the state.

Testing and screening

Testing has been a challenge for nursing homes in several ways. First, interviewees noted that they were not always clear on the federal and state guidelines for testing. Second, testing availability has been inadequate at times and test results often delayed.

Interviews with nursing home leaders across multiple facilities showed that there has been wide variation in the timeliness of test results. Among facilities that have greater financial resources, testing can be more easily coordinated with private laboratories that produce quick turnaround results in 24 to 48 hours. However, other facilities can wait up to two weeks for COVID-19 test results, which greatly limits their ability to properly cohort and keep residents safe. In these cases, symptom screening may be more heavily relied on than laboratory testing. But because there is asymptomatic spread, symptom screening is not a sufficient screening approach.

Testing best practices include pooled testing to address testing capacity concerns and collaboration with hospitals to improve test kit availability and more timely results. Some nursing homes have surveillance testing that is dependent on community infection and some have set up in-house testing. Strike teams can also be a useful resource to assist with on-site testing at nursing homes and physically take samples to labs. This approach has been successful in northwest Michigan.

Staffing

Staffing has been a major challenge for nursing homes in Michigan and nationally throughout the COVID-19 pandemic. Early on, many staff did not report to work due to fear of COVID-19 or because they were ill. Staff who have been able to work have increasingly experienced burnout that is damaging to their mental health and well-being and ultimately, harmful for residents.

Additional supports are needed for staff and nursing homes to ensure that staff are appropriately compensated, have the tools they need, and have access to mental health resources to support them with their very difficult jobs. Several best practices identified through interviews with nursing home leaders include offering additional pay, time off during non-surge periods, on-site meals or lodging, and connections to mental health and wellness resources.

Adequate staffing in nursing homes is critical to ensuring proper infection prevention and to keep both staff and residents safe.

Many health care workers in hospitals have been furloughed because of the economic impact of COVID-19 on hospital case-loads. These furloughed workers represent a potential staffing opportunity in nursing homes. Some states have created rapid response staff resources to provide short-term support for facilities with critical staffing needs; other states have implemented temporary certified nursing assistant (CNA) licensure to increase staffing. Michigan has a Rapid Response Staffing Resource available in 11 counties in southeast and western Michigan, but several nursing homes are unaware of this available resource.[ii]

Mental health, visitation, and other health care

In the early stages of the pandemic, states across the country limited visitors to hospitals, nursing homes, and other residential facilities to limit the spread of COVID-19. Because nursing home case rates are correlated with rates of infection in the community, such policies are essential in areas with high numbers of COVID-19 cases. However, limits on visitation have also resulted in increased social isolation and depression among nursing home residents and hardships for many families.

Limits on outside entrants into nursing homes have also resulted in reported difficulties in receiving other medical care for non-COVID-related issues (dental care, physical therapy, and the like). A number of nursing homes have tried to mitigate these problems using telemedicine and either e-visits or window-visits as a way to connect residents with their families. However, these approaches are not appropriate for every resident, particularly those with dementia and other cognitive and sensory conditions.

Visitation policies, as well as policies on the presence of ancillary providers, have also not been implemented consistently. Robert Gordon, director of MDHHS, issued an Emergency Order on June 30, pursuant to the Governor's Executive Order 2020-136 allowing for special exceptions in visitation policies.[iii] Many nursing homes and families are still not aware of these special exceptions, however, and some nursing homes are imposing more restrictive policies than what is permitted by the state because they are afraid that if they allow any visits, and there is community spread, they will be cited.

Hub evaluation

Background

In response to the COVID-19 surge in Michigan, and consistent with the federal and state guidance that was available at that time, MDHHS announced its regional hub strategy on April 15, 2020. A number of other states—such as Arkansas and Arizona—implemented similar strategies.

MDHHS's goal in establishing hubs was to more safely handle COVID-19 patient discharges from hospitals and to protect nursing home residents and staff. The facilities' purpose was to isolate COVID-19-positive admissions and residents from other non-infected residents.

MDHHS selected and began to designate regional nursing home hubs on April 18, 2020, to primarily care for medically stable COVID-19 patients discharged from hospitals. By May 28, 2020, the state had designated all 21 regional hubs.

MDHHS solicited interest in serving as a hub from all nursing home facilities. Facilities that volunteered to become hubs went through a vetting process with MDHHS based on several criteria. To be approved as a regional hub, nursing homes were required to have the capacity and floor plans necessary to isolate COVID-19 admissions and residents, maintain appropriate staffing levels, and document the ability to meet infection control requirements. The Michigan Department of Licensing and Regulatory Affairs (LARA) was consulted to confirm that applicant hubs had no outstanding issues with their recent long term care survey performance or financial stability.

Once selected, hubs received upfront payments of $5,000 per available hub bed to help facilities prepare to serve as a hub and staff at appropriate levels. This initial payment covered the first 30 days of hub operation, regardless of occupancy. Subsequently, hubs were reimbursed an additional $200 per occupied bed per day, for all residents, regardless of insurance coverage. For residents covered by Medicaid, hubs received the $200 per occupied bed per day in addition to the facility's regular Medicaid per diem rate. For all other residents, the state paid $200 per occupied bed and the other payers (Medicare, commercial) paid their standard rates.

Hubs allocated a portion of their total beds—ranging from 14 to 64—for a dedicated unit to house COVID-19 positive hospital discharges, transfers from other nursing homes, and transfers from within their own resident populations.

Through August 19, 2020, Michigan's hubs accepted 1,266 COVID-19 admissions from hospitals and other facilities. During this same time period, Michigan's non-hub nursing homes accepted 3,918 COVID-19 admissions into their facilities. Altogether, Michigan nursing homes accepted a total of 5,184 admissions to nursing homes from hospitals and other facilities across the state.

Methods and data limitations

For this analysis, data was extracted from Michigan's Statewide Long Term Care COVID-19 Report (LTC C-19 MI Report) in the state's electronic database, EMResource. The LTC C-19 MI data are based on self-reported nursing home COVID-19 cases, admissions, deaths, and PPE stock. In consultation with MDHHS, CHRT updated the data to include corrections reported by nursing homes and reporting errors.

Due to data quality issues, eight nursing facilities were excluded from the analysis, leaving 434 of Michigan's 442 total nursing homes. Of the 21 designated regional hubs, 20 are included in this analysis. One hub in Region 2N was removed due to data quality issues that could not be reconciled.

This analysis included cumulative data from March-August 19, 2020. Many facilities had data inconsistencies during the months of May, June, and sometimes through early/mid-July, as reporting guidelines and data validation approaches continued to evolve. Due to these inconsistencies, the study was not able to include detailed trend analysis or time-based analysis of COVID-19 admissions relative to cases.

Michigan's hub facilities were distributed among nine counties in the southeast, southwest, and northwest regions of the state. Southeast MI had the greatest number of hub facilities, with fourteen. The remaining regions had between one and three hub facilities. Half of the hub facilities in Southeast MI were located within Wayne County. (Figure 5)

Figure 5

Michigan's hub facilities were distributed among nine counties in the southeast, southwest, and northwest regions of the state.

Location of Hub Facilities
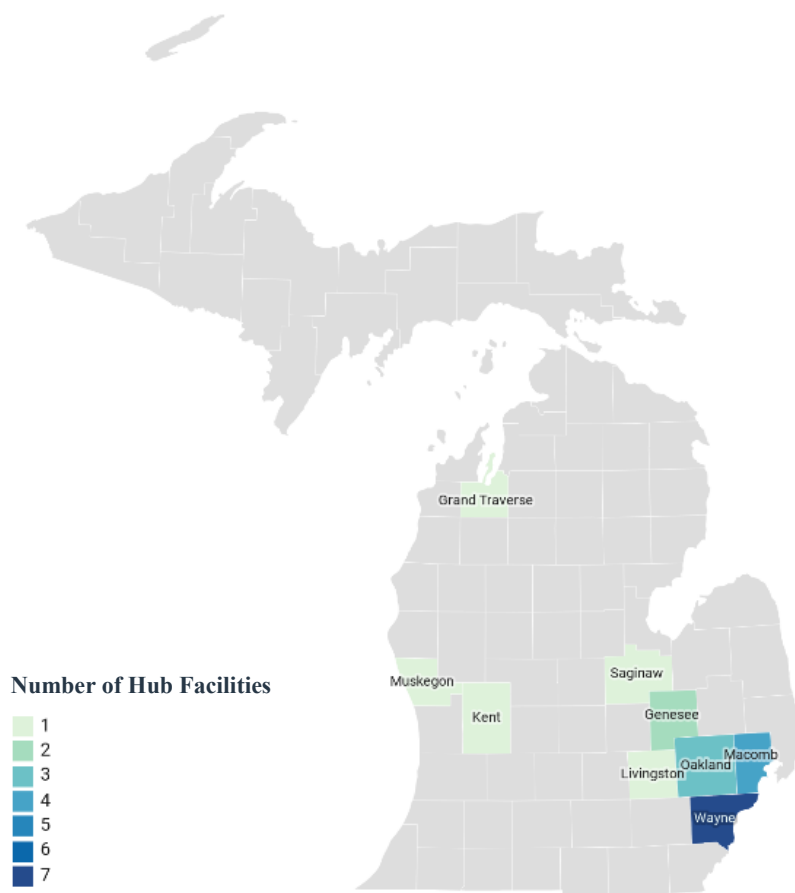
Created with Datawrapper

As new COVID-19 resident cases declined, some hub facilities requested to be decommissioned. As of August 19, there were eight hubs remaining.[3]

Nursing home resident cases and deaths

- Through August 19, 2020, 252 of 434 nursing homes[4] (58%) had at least one COVID-19 resident case. Michigan nursing homes had a total of 8,391 resident COVID-19 cases, representing 7.4 percent of all Michigan COVID-19 cases statewide. This is 1.8 percentage points higher than the national average of 5.6 percent.

- 185 out of 434 nursing homes (42%) had at least one COVID-19 resident death. Michigan nursing homes had a total of 2,087 resident COVID-19 deaths, representing 33 percent of all COVID-19 deaths statewide. This is 5.6 percentage points lower than the national average of 38.6 percent.

Nursing home staff cases and deaths

Through August 19, 2020, 111 out of 434 nursing homes (26%) had only staff cases and no resident cases; 51 nursing homes (12%) had neither staff nor resident cases. Michigan nursing homes had a total of 4,201 staff COVID-19 cases and 20 staff deaths.

Evaluation findings

The hub strategy was executed in a crisis situation and was an appropriate response to the surge of COVID-19 cases in Michigan. This finding is based on an analysis of aggregate hub and non-hub performance data reported between March 2020 and August 2020. The following analyses compare three categories of nursing homes: hubs, non-hubs with COVID-19 admissions, and non-hubs without COVID-19 admissions. Hubs and non-hubs with admissions are more comparable because all hub facilities accepted COVID-19 admissions. Additional detail is provided in Appendix B.

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[3] However, this analysis reports on data from the initial 20 hubs for consistency.
[4] Michigan has 442 total nursing homes; however, 8 have been excluded from analyses due to irreconcilable data inconsistencies

Figure 6

**Summary nursing home measures comparing hubs and non-hubs**

Nursing Home Measures	Hubs	Non-Hubs with Resident COVID-19 Infections		No Resident COVID-19 Infections
		With COVID-19 Admits	**Without COVID-19 Admits**	
Summary Totals				
Count Of Nursing Homes	20	166	86	162
Total Occupied Beds	1777	13480	6510	10081
Total COVID-19 Admissions	1266	3918	n/a	n/a
Total Resident Infections	1240	6437	714	n/a
Total Staff Infections	316	2961	652	272
Total Resident COVID-19 Deaths	244	1719	124	n/a
Rates				
COVID-19 Admissions Per Occupied Bed	0.71	0.29	n/a	n/a
Resident Infections Per Occupied Bed	0.70	0.48	0.11	n/a
Staff Infections Per Occupied Bed	0.18	0.22	0.10	0.03
% of COVID-19 Residents who Died	19.7%	26.7%	17.4%	n/a

Nursing home resident COVID-19 prevalence was positively correlated with county COVID-19 prevalence rates for both hub and non-hub nursing homes, meaning that as county COVID-19 infections increased there was a corresponding increase in nursing home infections. This correlation continues to be apparent in more recent data. The COVID-19 case surges in Upper Peninsula counties in late October, 2020 resulted in high nursing home infection rates in counties with high prevalence rates.

COVID-19 infection rates in hub facilities were also correlated with staff infection rates, consistent with community prevalence rates.

Among individual hub facilities, performance was variable. However, hubs overall had a lower percentage of deaths among residents with COVID-19 (20 percent) compared to all non-hubs (26 percent).

Interviews with selected hub facilities showed that hubs held a sense of pride in delivering care and staff stepped up to the challenge. MSF noted in an interview that the hubs they worked with in Detroit appeared to have better training and understanding of proper PPE use and infection prevention control protocols than non-hub nursing homes.

% of COVID-19 nursing home residents who died

(Bar chart: Hubs 20%, Non-hubs 26%)

Legend: ■ Hubs   ■ Non-hubs
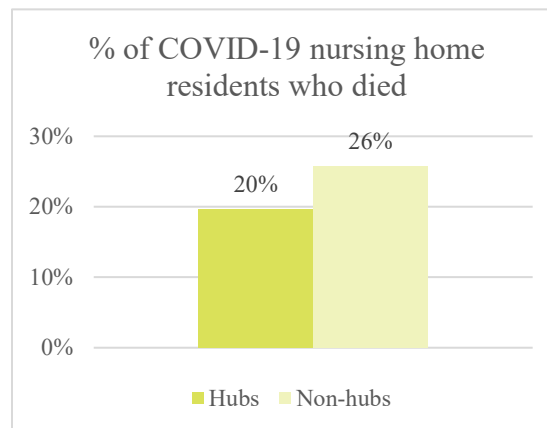
Recommendations

Structural recommendations

Case volumes are variable over time and health care capacity and infrastructure supports are not uniform throughout the state. Therefore, the structural approach to combatting COVID-19 should vary by region and over time.

Structural approaches should be modeled based on a range of expected volumes, an assessment of the quality and capacity of nursing homes in the region, and the cost and time to deployment. Generally, a freestanding facility is not the preferred approach due to cost and availability. Florida used this approach initially due to the availability of several new, unoccupied nursing homes; however, Florida is no longer prioritizing this design due to cost and lack of flexibility.

Current guidance from the U.S. Centers for Disease Control and Prevention (CDC) and CMS indicates that facilities capable of following the guidelines for cohorting, staffing, and infection control can safely manage COVID-19 cases on site. The preferred option is to discharge patients to a location designated to care for residents with COVID-19 infection. This is consistent with Michigan's hub strategy.

New hubs

The initial hub strategy was put in place quickly to meet an immediate need. While important criteria were used, there was no planning time and the state needed to work with facilities that had available capacity.

Michigan has more planning time now and there is also more information on best practices and key elements needed for safety. As a result, the state should reopen the hub application process with enhanced selection criteria, and should require all nursing homes and hubs to reapply.

Existing hubs that do not meet these criteria should be decommissioned. Hub selection should include on-site surveys (in collaboration with LARA) and include the selection criteria listed below. In addition, past performance of nursing homes should be considered in the new hub selection.

Proposed hub selection criteria

At minimum, potential new nursing home hubs should be in compliance with CMS and CDC guidance for infection prevention control, including cohorting, staffing, PPE, and training requirements. Based on reported best practices, additional criteria should be considered for hub selection. For example, death rates are widely used in quality

measurement toolkits. The COVID-19 death-to-case ratio is an important measurement for hub selection, and adjustments such as excluding hospice and do-not-resuscitate cases will assure more comparability in measurement.

Current evidence suggests that the CMS nursing home overall five-star quality ratings are not a reliable predictor of COVID-19 cases and death rates. However, the staffing component of the CMS quality rating system is significantly correlated with nursing home COVID-19 cases.[iv] Facilities with lower staffing star ratings generally had higher resident and staff infections and higher COVID-19 death rates.

Figure 7

CMS staffing star ratings summary among Michigan nursing homes

Staffing Star Rating	Facility Count	Resident COVID-19 Infections per Occupied Bed	Percent of COVID-19 Residents who Died	Staff COVID-19 Infections per Occupied Bed
1	4	0.35	34.3%	0.26
2	53	0.45	27.6%	0.17
3	104	0.36	22.7%	0.16
4	142	0.21	25.8%	0.12
5	102	0.08	22.2%	0.07

Communication between nursing homes and their referring hospitals, staff members, residents, and resident family members also needs to be improved across all facilities, but particularly among those applying to become a hub. A communication/continuum of care plan will facilitate transitions of care from hospital to nursing home, and to home when possible.

Based on peer reviewed research and interviews with key experts, the following criteria should be followed for selection of new hub facilities:

1. Demonstrated ability to meet or exceed CMS/CDC guidelines—based on a coordinated nursing home survey completed by LARA in collaboration with MDHHS–including, but not limited to:

    a) Ability to cohort residents in a separate wing or floor with different entrances and exits for traffic flow

    b) Dedicated staff to the COVID-19 unit (can only work on the COVID-19 unit and must not work in multiple facilities)

    c) Documentation of an adequate and consistent supply of PPE

    d) Documentation of training for both clinical and non-clinical staff on appropriate infection protocols, cohorting, and use of PPE

2. In facilities with more than five cases of COVID-19, historical performance on death-rate-to-case-rate ratios that meet a minimum threshold, excluding hospice and DNR patients[5]

3. Documentation that the facility has a communication/continuum of care plan with referring hospital(s) and a communication plan for staff, residents, and families

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[5] Will require adequate data reporting.

4. Documentation that the facility achieves at least three out of five stars on the CMS rating for staffing measure

In addition to these selection criteria, the hub process and oversight should be strengthened. Weekly oversight of the hubs should continue with expanded engagement, or with a virtual component, and additional training should be provided to the hubs with some dedicated focus from the IPRAT teams. Hubs should be prioritized for PPE and training. Finally, improvements to data reporting from the hubs will be essential for MDHHS to track their effectiveness and to be able to respond to critical needs over time.

Cohorting residents

Cohorting is the process of isolating multiple individuals with a common disease together or quarantining close contacts of an infected person together as a group. This practice helps prevent the spread of COVID-19 by limiting the cross-over of residents and staff as much as possible.

All nursing homes need an infection control plan that includes how they are going to cohort residents before a case of COVID-19 arises in the facility. Ideally, cohorting units should be physically separate from other rooms or units housing residents without confirmed COVID-19. Designated health care personnel and environmental services staff should be assigned to this unit with separate entrances and spaces for breakrooms, bathrooms, and work areas.

Cohorting recommendations

1. **Cohorting plans should be in place early (before a case of COVID-19 arises).**

   Having a plan in place for how to cohort residents based on COVID-19 status, even in facilities that do not have experience serving residents with COVID-19 or facilities that do not have any active cases of COVID-19, will help prepare facilities to implement these measures for COVID-19 positive care when a case arises.

2. **Cohorting on a separate floor is best when possible. Separate wings/units are safe with adequate PPE and other safety protocols.**

   CDC guidance states that depending on facility capacity (e.g., staffing, supplies) to care for affected residents, the COVID-19 care unit could be a separate floor, wing, or cluster of rooms. The practice of cohorting on separate floors when possible was highlighted as a best practice by one of the nation's top performing nursing homes. Cohorting on a separate floor makes it easier to separate staff, minimizes interactions between staff and residents among cohorts, and allows for easier designation of separate space, entrances, breakrooms, and bathrooms. If a separate floor is not available, cohorting in a separate wing, unit, or designated cluster of rooms are all safe options with appropriate staff and PPE.

3. **Three cohorts: positive, negative, and persons under investigation (PUI) should be established.**

   Persons under investigation are individuals who have been in close contact with a person with a confirmed infection and/or may have been to a place where there was an outbreak. These individuals need to be separately quarantined from other patients until it can be determined whether or not they are COVID-19 positive or negative. They can then be placed on the appropriate floor. Residents in quarantine should not be allowed to intermingle and all cohorts should be kept separate from one another.

Hospital discharges

Across the U.S., surge capacity planning and support was initially focused on hospitals and how to safely discharge patients if hospitals approached capacity. On March 13, 2020, the CDC and CMS issued guidance stating that nursing homes could accept COVID-19 admissions as long as they used transmission-based precautions. The knowledge of what defined appropriate precautions, including the structural and procedural processes required to keep nursing home residents safe, has evolved rapidly during the pandemic based on research and clinical experience.

The understanding of the length of time and indications for transmission have also changed over time. As of mid-August, 2020, CDC guidelines state that persons with mild to moderate COVID-19 remain infectious no longer than 10 days after symptom onset. Persons with severe to critical illnesses or those who are severely immunocompromised likely remain infectious no longer than 20 days after symptom onset, and transmission-based precautions are no longer needed.[v] CMS data through June 16, 2020 indicates that nationally, many patients admitted to nursing homes from hospitals were likely no longer contagious due to their long length of hospital stay (32 percent of COVID-19 patients stayed more than 10 days in the hospital; 9 percent stayed more than 20 days).

Hospital discharge recommendations

1. **If COVID-19 positive patients can be maintained in hospitals for the full recommended CDC isolation period, that would be desirable but it is often inconsistent with reimbursement policies of payers and capacity needs for other patients.**

    Per CDC guidance, patients can be discharged from the hospital whenever clinically indicated. If patients are nearing the end of the time period where transmission-based precautions are needed (10-20 days) and the hospital has capacity, it may be beneficial to keep the patient in the hospital for the full recommended isolation period. However, Medicare and most commercial health plan reimbursement policies penalize hospitals for keeping patients as inpatients when they no longer need hospital level care. And, some hospitals are challenged to have enough beds to serve those who need hospital level care for other medical issues. As a result, there will be many cases when patients need to be transferred to other facilities before the full CDC recommended isolation period is completed. Most states are now discharging such patients to nursing homes when they need nursing home level care. Florida is an example of a state that utilized hospitals initially and then shifted to discharging COVID-19 patients to nursing homes.

2. **For patients that have not completed the full recommended CDC isolation period (10-20 days) but no longer need hospital level care, transfer to a hub is preferred.**

    CDC guidance released on August 10, 2020, noted that it is preferable for a patient to be discharged to a location designated to care for residents with COVID-19. This guidance is consistent with Michigan's hub strategy.

3. **If a hub transfer is not possible or desirable for specified reasons, patients can be transferred to certain other nursing homes.**

    During the surge in cases in Michigan in April, 2020, demand was so high that hubs were not able to take all transfers from hospitals. In addition, some hubs were located far away from residents' homes or transferring hospitals. As such, if a surge occurs again, non-hub facilities should be prepared to care for COVID-19 positive transfers if a hub transfer is not feasible.

Non-hub facilities should meet all of the same criteria as the hubs with modifications in two areas to recognize that non-hubs will likely have lower volumes of COVID-19 positive residents than hubs. The two modifications from the hub criteria are: 1) criteria 1b below does not require staff be dedicated to the COVID-19 unit because volumes are likely to be lower in the non-hubs and such a standard would not be feasible; and, 2) criteria 4 below requires that non-hubs meet a minimum CMS two-star staffing ratio rather than three stars to enable more geographic access in communities where facilities with three star and above staffing ratios are limited. Patient safety should still be assured by requiring the non-hubs eligible to take transfers from hospitals before the full CDC isolation period has been met, self-certify, and provide documentation that they meet all of the following criteria:

1. Demonstrated ability to meet or exceed CMS/CDC guidelines—based on a coordinated nursing home survey completed by LARA in collaboration with MDHHS–including, but not limited to:

   a) Ability to cohort residents in a separate wing or floor with different entrances and exits for traffic flow

   b) Certification that staff do not work in multiple facilities

   c) Documentation of an adequate and consistent supply of PPE

   d) Documentation of training for both clinical and non-clinical staff on appropriate infection protocols, cohorting, and use of PPE

2. In facilities with more than five cases of COVID-19, historical performance on death-rate-to-case-rate ratio that meets a minimum threshold, excluding hospice and DNR patients[6]

3. Documentation that the facility has a communication/continuum of care plan with referring hospital(s) and a communication plan for staff, residents, and families

4. Documentation that the facility achieves at least two out of five stars on the CMS rating for staffing measure

Non-hub facilities that have had no residents or admissions in the past with COVID-19 (COVID naïve facilities) should not be eligible to take patient transfers from hospitals until the patient has completed the full CDC recommended isolation period.

Continuity of care

Interviews with experts across the country indicated that strong partnerships between hospitals and nursing homes were a key factor in successful transitions of care for COVID-19 patients, including care coordination, infection control training, and access to PPE and testing. For example, several nursing homes in Ohio formed a partnership with a local hospital, local health department, and state surveyors to improve staff training on infection control to enable admissions from hospitals.

In Michigan, the Henry Ford Health System (HFHS) held daily phone calls with nursing homes and community-based long-term care organizations to discuss hospital capacity and status as well as each organization's needs during the COVID-19 surge. HFHS also shared PPE with partner nursing homes and processed lab tests more quickly than average.

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[6] Will require adequate data reporting.

Recommendations

1. **All nursing homes should have formal, collaborative arrangements with hospitals in preparation for safe admission of COVID-19 patients.**

   Interviews indicated that most hospitals and nursing homes have good referral relationships, however, formal arrangements are needed for better continuity of care for COVID-19 patients. MDHHS should work with the Michigan Health and Hospital Association and nursing home associations to develop a collaborative system.

   Key components of formal, collaborative arrangements include:

   • **Care coordination and continuity of care plans:** When patients are discharged from hospitals there should be a warm handoff between discharge planners and nursing homes, with an identified contact at the hospital to support continuity of care in case the nursing home needs back up support.

   • **Training and back-up support for PPE, testing and infection control:** Not all hospitals may have excess PPE and testing capacity, but where available, providing these supports to nursing homes can help address critical shortages. In addition, many hospitals have expertise in infection control that can benefit nursing homes. Research has indicated that there are several advantages to this approach, including an improvement in policies and practices due to shared resources from well-developed hospital-based infection prevention teams, assistance with staff training, standardized prescribing practices, and enhanced knowledge transfer that will improve efficiency.[vi]

2. **Local public health departments and nursing homes should establish collaborative relationships to provide nursing homes with more resources and tools to help with the COVID-19 pandemic.**

   Local public health departments can be a source of training and guidance for nursing homes. In addition, local public health departments can collaborate with nursing homes to help with access to testing and PPE. Building such collaborative relationships will be of great value in the current pandemic, but also in the longer term to strengthen community-based care coordination in support of nursing home residents. MDHHS can facilitate these collaborative relationships and encourage strong ties at the local level.

Home and community-based services

Individuals who are eligible for nursing home care but choose to remain in a home-based setting may need additional home and community-based services (HCBS) to successfully manage COVID-19 recovery in the community. Additional funding or incentives to managed care organizations (MCOs) may be required to enable individuals with COVID-19 to remain in their homes or return to their homes following hospitalization.

States are using CARES Act funding, waivers, and Medicaid State Plan Amendments (SPAs) for funding and approaches to change or add new services. Rhode Island used CARES Act funds to increase the use of HCBS and to increase pay for patient care assistants with home health agencies. Arizona incentivized Medicaid health plans to provide additional HCBS, regardless of benefit eligibility, for COVID-19 patients discharged to home.

All 50 states have used the Section 1915(c) waiver, Appendix K, to request pandemic- related changes that impact HCBS. For service delivery, Michigan's waiver allows HCBS to be provided in alternative settings. Other states have also added new services and supplies such as home-delivered meals (15 states) and adaptive technology (six states).

Recommendations

1. **Identify options for Michigan Medicaid programs (MI Health Link / PACE / MI CHOICE) to increase funding for, access to, and safety of home-based services for beneficiaries.**

   Both member choice and cost savings provide the impetus to expand services that will enable a home-based option for COVID-19 care. Monitoring and taking advantage of federal funds as they become available for HCBS can help support these beneficiaries. This may include future federal emergency funds, emergency related program changes using the SPA, or future waiver requests.

   MI Health Link and MI Choice plans identified issues with lack of PPE availability for home-based members with COVID-19 and their caregivers, which would enable them to return home following a hospital stay. While MCOs/ICOs are responsible for care management for their members, the availability of PPE and training may limit their ability to encourage this option in discharge planning. In future emergency planning that addresses the continuum of care, the state should consider the needs of home care and community-based providers as they work to serve COVID-19 patients.

2. **MCOs/ICOs should collaborate with hospitals to facilitate discharge of eligible COVID-19 patients to home settings, including care coordination and supports.**

   MCOs and ICOs have a shared goal of cost-effective transitions of care that include member choice and appropriateness of care setting. MCOs and ICOs can participate in community partnerships with hospitals and other stakeholders to identify and resolve gaps in home-based services that limit the ability to appropriately discharge COVID-19 patients to home settings.

3. **For community-based COVID-19 cases that do not require hospitalization, the state should provide incentives for health plans to maintain adequate HCBS and PPE supplies – including nutritional supports delivered to member homes.**

   Nutrition support and food delivery were identified as top priorities to enable individuals with COVID-19 to remain in the community and to help those who were isolating avoid infection. Texas and Arizona authorized their MCO plans to provide expanded benefits to members, regardless of medical eligibility, for nutrition support.

Process recommendations

Guidance and training

Training and education of nursing home staff, both clinical and non-clinical, is critical to the prevention and control of COVID-19 outbreaks in nursing home settings. Staff in nursing homes are being flooded with information from multiple sources regarding infection control protocols, donning and doffing of PPE, visitation policies, and protocols on screening, testing, and cohorting. Staff receive regular updates on the latest guidance, but teaching them how to carry out that guidance and educating them on the rationale or the "why" for each protocol is critical.

Local public health departments, corporate nursing homes, and organizations with interests in aging and the rights of seniors noted that organizing regular community calls was a very helpful strategy for quickly sharing information as the COVID-19 pandemic evolved. MDHHS conducts weekly calls with nursing home associations and facilities to discuss the latest guidance. These calls should continue because they are crucial and will be important to maintain throughout the pandemic.

Recommendations

Guidance

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

   Many corporate nursing homes identified a team or individual who would check for updates on guidance every day and condense and share that information among all of their locations. For smaller nursing homes, the task of sorting and sharing new guidance often falls to the director of nursing or an administrator, and they already have many other responsibilities. Having MDHHS track, consolidate, and communicate guidance to nursing homes would take the administrative burden off facilities and reduce the inconsistencies in the way facilities may be interpreting and applying guidance.

2. **MDHHS should review CMS and CDC guidance and determine whether specific components, or the guidance in its entirety, should be required under state policy; identify additional requirements the state would like to incorporate that would go beyond CMS and CDC guidance; and select the most effective vehicle for implementation (Medicaid Emergency Disaster Relief SPA, executive order, or Medicaid 1135 waiver amendment).**

   Much of the federal COVID-related guidance for nursing homes is written in a manner that suggests it is optional, with terms such as "should" or "consider." Mandating specific guidance could make it clearer to nursing homes what is actually required and whether or not they could be penalized for not following a particular guideline.

   The state could choose from multiple vehicles to incorporate CMS and CDC guidance as state policy. One option is the use of an Emergency Disaster Relief SPA to enable the state to quickly create state policy and requirements with federal approval. Additionally, the state can include state-specific nursing home requirements that go beyond CMS and CDC guidance, all subject to Federal Financial Participation with a SPA. These requirements would end when the federal emergency declaration ends. Another option is an executive order that has the full weight of state law but can be overruled by the courts or the legislature. A third option is the 1135 waiver amendment that Michigan has already utilized for several COVID-19 emergency provisions, however the 1135 carries limits to what can be accomplished.

3. **MDHHS should develop and disseminate key elements of guidance in easy to use formats (e.g., checklists) for local public health departments and long-term care providers.**

   The challenge of interpreting and applying rapidly changing guidance and policy was repeatedly mentioned by interviewees from nursing homes and local public health. The creation and sharing of a best practices checklist that is actionable and easy to understand for local public health and nursing homes could solve some of these difficulties in simplifying and applying guidance, particularly around the topics of visitation, screening, testing, PPE, cohorting and other IPC protocols.

Training

4. **Build on Médecins Sans Frontières training/tool modules**

   During their time in Detroit. Médecins Sans Frontières (MSF) developed a training module to address, prevent, and mitigate COVID-19 outbreaks. Separate modules were designed for clinical and non-clinical

staff. MSF provided their training modules to the nursing schools at Wayne State University and University of Detroit Mercy. The MSF model can be molded to the individual needs of each nursing home and can be expanded to other cities and environments through other schools of nursing. Local nurses in graduate-level nursing programs would be well suited to the imbedding practices of working hands-on in nursing homes alongside nursing home staff to teach proper IPC protocols. It is important that these programs do not take a punitive approach to training and implementation but rather, apply a learning approach to improve practices.

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

   IPRAT is a team of subject matter experts from the communicable disease division of the Michigan Department of Health and Human Services. IPRAT supports local public health departments and long term care facilities by helping with questions about infection prevention, PPE, and CDC guidance interpretation. IPRAT has been an excellent resource to nursing homes to help apply best practices and IPRAT has recently transitioned from remote to in-person technical assistance. Expanding IPRAT with more teams and staff, and increasing accessibility for nursing homes and local public health departments, would be enormously beneficial to nursing homes and local public health.

Personal protective equipment supplies and processes

PPE and infection control measures are essential to stemming the spread of COVID-19 in nursing homes and elsewhere. PPE helps prevent COVID-19 from spreading through airborne or direct contact transmission that causes the virus to infect others. In nursing homes, PPE is especially important given the nature of close contact between and among residents, staff, and visitors.

Nursing homes are required to use PPE to protect residents and staff from COVID-19 transmission. Nursing homes are also required by CMS to track PPE supplies and to further conserve use of all available PPE. Finally, nursing homes are expected to work with state and local health departments to obtain and maximize PPE to address needs.

PPE challenges among nursing homes continue and include inadequate supply, difficulty in obtaining PPE when needed, and, understanding the proper use of PPE including issues such as donning and doffing of gowns and when extended wear is appropriate and when it is not.

Best practices focused on strategies to ensure adequate supply of PPE within nursing homes include:

- Corporate nursing homes with multiple locations re-distributed supplies within their system.
- Several states centrally tracked PPE and shifted supplies between nursing homes depending on resident census.
- Many nursing homes had stockpiled PPE in the event of another COVID-19 outbreak.
- Tools such as the CDC Burn Rate Calculator were used to track and report the sufficiency of PPE.
- Partnerships with acute care hospitals were established to obtain sufficient PPE supplies.
- Purchasing and washing gowns is a best practice to ensure an ongoing supply.

Recommendations

1. **Use PPE reported data to support statewide tracking and distribution.**

MDHHS should work with nursing homes to review and analyze reported data as a means to support statewide tracking of PPE. Using that data, MDHHS can support nursing homes in re-distributing available PPE based on prevalence rates as needed, in collaboration with nursing homes and, potentially, hospitals.

2. **Track all available federal PPE supplies and PPE funding and communicate to nursing homes.**

   Announcements of available PPE supplies and funding are published by CMS. MDHHS can support nursing homes by tracking and reporting on federal PPE resources as well as available funding. In doing so, MDHHS can ensure that nursing homes in Michigan maximize all available federal support.

3. **Develop a process to share PPE between facilities if cluster outbreaks occur, facilitated by MDHHS with voluntary participation by nursing homes and hospitals.**

   Using available data noted above, MDHHS can assist nursing homes by developing processes to share PPE across different facilities, based on prevalence rates and admissions, in the event that a cluster outbreak occurs at a particular location with voluntary participation by nursing homes and hospitals.

Screening and testing

Testing nursing home residents and staff is a critical underpinning to control the spread of COVID-19. Testing is essential in nursing homes given the ease of spread and the potential severity of illness that occurs among nursing home residents with COVID-19

Testing availability continues to present significant challenges everywhere in the U.S., including in nursing homes. Virtually all nursing home interviewees reported challenges in both obtaining and getting timely processing of COVID-19 tests. In particular, laboratory processing time can still take several days, up to a period of weeks, for test results.

CMS and CDC guidelines also present unique challenges for COVID-19 testing as guidelines continually change.

On August 25, 2020, for example, CMS announced mandates to test residents when there is an outbreak or when residents show symptoms. In addition, CMS increased reporting requirements on COVID-19 testing in nursing homes. Failure to comply with these new requirements, which will be mandatory and tied to Medicaid and Medicare provider status, can result in significant financial penalties for non-compliance. This is a substantial shift from prior CMS testing guidance that served as guidelines, not mandates.

States and nursing homes have used creative approaches to improve access to testing. For example:

- Arkansas coordinates testing (along with coordinating PPE) to support nursing homes across the state.

- A Massachusetts nursing home reported collaborative efforts with a partner hospital that provided testing kits as well as rapid turn-around on testing (under 24 hours). After the initial surge, they trained in-house clinical staff to expedite testing and developed the capacity to process labs internally. They also used multi-use swabs/tests for Flu, RSV, and COVID to distinguish between conditions.

Recommendations

1. **Michigan should establish pooled testing (and adjust based on expected prevalence in sample). For individuals screened often, pooled testing can significantly increase testing efficiency. Pooled testing should be adjusted based on expected prevalence in sample.**

Pooled testing is a technique whereby multiple samples are combined and one laboratory test is conducted on the combined or "pooled" sample to determine COVID-19 positivity in a group.[vii] Laboratories that are certified under the Clinical Laboratory Improvement Amendments (CLIA) can use a specimen pooling strategy to test populations for COVID-19 using a test authorized by the Food and Drug Administration, which regulates pooled testing efforts. Pooled testing is designed to increase testing capacity and efficiently, especially for individuals who are screened frequently for COVID-19.

If a pooled test result is negative, then all specimens can be presumed negative with a single test and no further tests are needed. If the test result is positive or cannot be determined, then all of the specimens in the pool must be retested individually. The advantages of this two-stage specimen pooling strategy include conserving resources, reducing the amount of time required to test large numbers of individuals, and a decreased cost of testing.

It is important to adjust pooled testing based on community prevalence. While in most cases any pooling will reduce the number of tests needed, optimal pool size depends upon the expected prevalence of COVID-19. For example:

- For a prevalence of 0.5 percent, batches of 15 are best, and would reduce testing by 86 percent. While such low prevalence is not now seen in the general population, it could be the case when testing is repeated (e.g., daily) on the same people, as in a nursing home, factory, or school. That would make such frequent screening much more feasible.

- For prevalences in the range 15-30 percent, batches of three are best and would reduce testing by 10-30 percent.

- For prevalences above 30 percent, pooling is not effective (i.e., you do more tests by pooling).

2. **Testing supplies should be directed to areas based on community and nursing home prevalence**.

It is important to ensure that adequate testing supplies are available in areas with the highest prevalence rates. This is especially important given the correlation between community and nursing home prevalence, and the opportunity to prevent further spread by testing individuals who are potentially infected.

3. **MDHHS should update staff and stakeholders regarding new federal testing guidelines for nursing homes that was announced (but not yet issued) on August 25, 2020.**

Given known challenges in tracking and distributing guidance, MDHHS should support nursing homes and stakeholders regarding changes in federal testing guidelines such as those announced on August 25, 2020. As noted elsewhere, the ability to track changes in guidelines, federal supplies and funding, and new guidance will support the ability of nursing homes to better manage infection control.

Staffing

Staffing was identified as one of the most critical and ongoing challenges nursing homes have been facing throughout the COVID-19 pandemic. Proper IPC protocols are critical for keeping residents safe, and cannot be followed without adequate staffing. Due to staff shortages and a number of other challenges, staff in nursing homes and local public health departments continue to experience burnout, and unfortunately, negative media and some organizational cultures that are fearful of regulatory sanctions have created an additional emotional burden for nursing home staff.

Recommendations

1. **Increase staff compensation (e.g., give staff additional hazard pay).**

    Beyond the COVID-19 pandemic, the minimum pay for caregivers should be increased. Michigan's average caregiver salary is listed at $11.70 per hour, slightly lower than the national average.[viii] A Michigan bill for supplemental funding included a provision for a $2 per-hour pay raise for direct care workers[ix], but additional increases to base wages are needed to provide compensation more commensurate with the difficulty of the work in nursing homes.

2. **Require nursing homes to have a plan to address staff burnout through additional supports (wellness resources, EAP, occupational health, and sick leave).**

    Nursing home staff continue to experience feelings of burnout. Staff have experienced a great deal of change, loss, fear, and grief throughout the COVID-19 pandemic, all while taking care of vulnerable residents as frontline healthcare workers. They worry about their residents, and they grieve for the residents and fellow staff members that have died due to COVID-19.

    Additionally, these caregivers often work long hours with low wages. Facilities should be required to have a plan to mitigate burnout among staff, such as increasing access to occupational health services, adequate sick leave policies, and promotion of wellness resources.

    Some nursing homes took innovative approaches to addressing feelings of staff burnout, such as "appreciation pay," and providing meals or lodging to staff during a surge in COVID-19 cases. Although some of these additional supports may not be feasible for all facilities to offer, it is important to have a plan in place to address the mental and physical well-being of staff.

3. **Develop a system connecting furloughed hospital staff to open positions in nursing homes.**

    Various types of staffing portals and regional surveys to connect people with vacancies in long-term care positions have been successful in California (Santa Clara County), Indiana, Louisiana, Massachusetts, Rhode Island, and other states and counties across the country.

    A Michigan staffing portal or statewide system to connect people looking for employment with jobs in long-term care could address multiple concerns at once; the rise in unemployment and the LTC industry staffing shortages and growing needs. MDHSS can work with MHA and Michigan Works to develop such a system that could help address nursing home staffing needs and connect furloughed hospital staff to available jobs.

4. **Make nursing homes aware of the state's Rapid Response Staffing Resource and expand to additional counties.**

    Nursing homes sometimes reported lack of awareness of available resources or assistance. Currently, MDHHS is offering Rapid Response Staffing Resources in 11 counties in southeastern and western Michigan. This resource offers short term (72 hours or less, consecutively) support with staffing assistance for facilities facing shortages. A maximum of one registered nurse and four certified nursing assistants or resident care assistants can be requested. The Rapid Response Staffing Resource could greatly assist nursing homes in the 11 participating counties that are experiencing emergency staffing shortages.

This program could be a major source of support for facilities, particularly for those with emergency staffing needs. In the future, this program could be considered for expansion outside those 11 counties if the need for emergency staffing persists.

5. **A full-time "infection preventionist" position without other job responsibilities is preferred.**

    In many facilities, the infection preventionist is also the director of nursing. The director of nursing in most nursing home settings has a large caseload and a wide range of responsibilities, including: overseeing the care of all residents, managing all nursing staff, communicating with families, creating care plans, budgeting, and implementing new policies according to changing regulations and best practices. Hiring a separate full-time employee for infection prevention is a necessary step to guarantee that infection prevention strategies receive the full-time attention that is necessary, particularly during the COVID-19 pandemic.

6. **State policy is needed to prohibit nursing home staff from working at multiple facilities (with some exceptions).**

    Often, nursing home staff that work for corporate facilities may work shifts at multiple locations; this increases their risk of exposure of COVID-19 and in turn, their risk of exposing more residents. Staff may unknowingly introduce the virus into each facility, particularly in asymptomatic cases or situations where there are long delays in receiving test results.

    Although staff in Michigan are currently tested weekly, some facilities still report significant delays in receiving results (which may be as long as two weeks), which hinders the ability to keep both staff and residents safe. In order to minimize risk of exposure of COVID-19 to multiple facilities, staff should work at one location. Exceptions to this requirement may include specialized staff with limited time at a facility.

Access recommendations

Behavioral health and ancillary services

COVID-19 has imposed new challenges on access to care for residents of nursing homes. Access to key physician health support like physical therapy, occupational therapy and dental care, has been more limited at many nursing homes since COVID-19. Increased isolation and decreased mobility of residents also often worsen both physical and mental health.

Patient advocates have raised concerns that many residents are not getting access to services, such as clergy, compassionate care visits, bathing (if a facility has communal bathroom spaces), and grooming/barbers. Key medical services, such as occupational therapy, physical therapy, speech therapy, and mental health services may also not be provided, or not be provided in a way that promotes health. And many research projects that could benefit nursing home residents were stopped as the pandemic hit and have not been permitted to re-engage.

Recommendations

1. **Require and approve nursing home plans that ensure adequate access to ancillary health care services such as physical therapy, occupational therapy, dental treatment, etc. In addition, enable nursing homes to resume health services research as appropriate.**

While telehealth visits may be appropriate and adequate for some care, it is not appropriate for all care (e.g., physical therapy). Facilities should establish plans for meeting all the health needs of their residents, including in person care when needed.

2. **Require and approve nursing home plans to ensure adequate access to address residents' behavioral health needs (individual care plans for psychosocial needs).**

With the decline of mental health in residents as a result of their social isolation, in conjunction with the emotional toll that living in a pandemic can have on any person (i.e., worrying for the health of loved ones), there is a considerable need for accessible and adequate mental health services. Such services can be safely provided to residents in a telehealth format, using video or telephone calls.

3. **Enable non-COVID nursing home residents to socialize with each other to reduce social isolation, as long as there is adequate testing and infection prevention and control.**

Allowing residents who have tested negative for COVID-19 to socialize while following proper infection prevention protocols can be a successful way to alleviate some of the negative effects social isolation has on resident mental health. Many residents establish bonds with others in the nursing home; enabling these relationships to continue is important for residents' health. In order to do so, however, facilities must have the necessary PPE supply for residents to use and adequate testing.

Visitation

To prevent COVID-19 from being brought into a facility and spread to residents and staff, states across the country have restricted visitation of those not directly involved in patient care in nursing homes. Electronic visits through FaceTime or another platform, as well as window visits, have been used in a number of states, including Michigan, as an option to help residents safely connect with their families. However, these types of visits may not be appropriate for every resident, particularly those with dementia or other cognitive disorders.

Executive orders in Michigan have restricted visitation, but allow MDHHS to provide guidance on exceptions in special circumstances. On one hand, there is no doubt that limiting the number of potential COVID-19 carriers into a facility lowers the odds of the virus getting into the facility. On the other, tight restrictions are creating environments of isolation for the residents that live in them - often to the detriment of their own health.

Recommendations

1. **Michigan should broaden state visitation policy to enable outdoor visitation in accordance with CMS guidelines.**

As of June 30, 2020, Michigan visitation policy for residential facilities (including all long-term care facilities) allowed in person visits for residents with visual, hearing, or speech impairment who need help with activities of daily living and when a resident is in "serious or critical condition or in hospice care." Other in person visits remain prohibited by executive order.[x]

On May 18, 2020, CMS issued guidance regarding facility reopening, including information on visitation depending on each state's specific reopening phase.[xi] On June 23, 2020, CMS released additional clarification to their visitation guidance. As of June, CMS guidance allows for some flexibility for controlled visitation, including allowing facilities to offer outdoor visitation for residents without COVID-19 or who have recovered from COVID-19 in certain circumstances.

CMS notes that "facilities should still ensure all actions for preventing COVID-19 transmission are followed. These actions include screening all visitors for symptoms and fever, asking both residents and visitors to wear a cloth face covering or face mask, performing hand hygiene (e.g., use alcohol-based hand rub), maintaining social distancing at all times, and ensuring the items in visitation spaces are cleaned and disinfected routinely. If outdoor visitation is conducted, facilities should have a process to limit the number and size of visits occurring simultaneously to support safe infection prevention actions (e.g., maintaining social distancing). We also recommend limiting the number of individuals visiting with any one resident (e.g., two visitors for one resident visit)." [xii]

2. **Michigan should enable controlled indoor visitation in areas with low community spread, and in compliance with CMS guidelines.**

    In many instances, family members have been heavily involved in caring for their loved ones, even when they're in a facility. The emergence of COVID-19 has disrupted this support and many families are asking for this support to resume. Because of the importance of in person visits for many residents in nursing homes and where outdoor visits are not possible, in areas where there is low community spread of COVID-19, it is reasonable to allow in-person visitation in a very limited capacity and with several safeguards.

    CMS guidance indicates that "nursing homes may decide to create safe spaces within the facility, such as see-through separation walls or other such areas, so that residents may physically see their family members (if outside visitation is not conducted)." [xiii] Some states are using plexiglass cubicles to facilitate safe visitation indoors or outdoors. For example, in the first facilities that started using the plexiglass booths, the facilities were able to facilitate nearly 400 visits with 200 residents. [xiv]

    "Low community spread" is a moving target and can change at any given point in time as well as vary across regions. In Michigan, a case level can be established based on mistartmap.info levels. Consultation with an expert epidemiologist indicated that a COVID-19 case rate below 40 new cases per million would be a reasonable level to consider, and a case rate of 20 could be considered as a starting point to test this strategy. A mid-August point in time showed that more than 20 Michigan counties met the threshold of 40 or less new COVID-19 cases per million.

    Where controlled indoor visitation is possible, and in compliance with CMS guidance, nursing homes should identify one to two individuals as designated visitors for each resident. Prior to the visit, visitors must undergo proper training on correct infection prevention and control procedures, such as how to properly don/doff PPE.

3. **State visitation policy needs to be communicated on an ongoing basis so it is more transparent and clear to nursing home residents and their families.**

    Since visitation guidelines are being continually updated to adapt to the changing COVID environment, it is important to clearly communicate these changes to nursing home residents and their families. Families and residents need to understand what visitation the State permits and whether individual nursing home policy is more restrictive than State policy.

4. **Nursing homes that follow all visitation guidance should be assured that they will not be cited for an adverse event as a result of visitation.**

    Nursing homes have had challenges in implementing visitation protocols due to a lack of clarity and understanding.

Although Michigan policy does allow for visitation in certain circumstances, findings from interviews with nursing home leadership and other organizations show that these policies are not well understood and that several nursing homes have a high degree of fear of penalties or citations. This fear is likely contributing to the reluctance of facilities to enable certain types of visitation, even when it can be done safely. The assurance that nursing homes won't face penalties if they follow all guidance will need to be explicit.

Collaboration with managed care organizations

Managed care organizations (MCO) can be partners to nursing homes and the state by working with their contracted nursing home partners to support the delivery of care for members who have been diagnosed with COVID-19. MCOs should consider carrying through guidance and recommendations in their contracts with nursing homes, distribute and interpret relevant guidance to nursing homes in their network, and further educate contracted nursing homes regarding the needs of members.

In addition, MCOs can play a valuable role in delivering care management services to members diagnosed with COVID-19. Another valuable MCO role is to identify and deliver cost-effective, quality-enhancing benefits and services that may be outside of the formal benefit package to members diagnosed with COVID-19.

Recommendations

1. **The state can reduce the administrative burden on MCOs for COVID-19 members to facilitate access and care management services.**

    MDHHS should review the potential to decrease administrative burdens on MCOs who are serving members diagnosed with COVID-19, particularly where such changes would enhance quality or access for those members.

    For example, to the extent the state requires certain MCO utilization review practices (e.g., prior authorization), the state can eliminate these requirements to expedite access for members with COVID-19. In addition, similarly to Arizona and Texas, the state can enable MCOs to provide additional HCBS to support members with COVID-19 at home during their recovery.

2. **The state should collaborate with MCOs to develop value-based incentive structures for nursing homes to help with a) expedited testing and lab processing, b) PPE acquisition and distribution, and c) financial incentives to improve quality and access.**

MDHHS may look at opportunities to develop value-based incentives that support key services and supports that are of primary importance during the pandemic. For example, value-based incentives can be designed to promote more rapid testing and lab processing with contracted vendors. This could also include incentives for contracted providers to share and distribute PPE in areas where prevalence rates warrant such distribution practices.

Operational recommendations

Data and reporting

MDHHS and Michigan's nursing homes were unprepared to handle the urgent needs for data gathering, reporting, management, validation, and analysis when the COVID-19 pandemic surged in Michigan.

Prior to the pandemic, MDHHS had recognized the need to modernize its health data infrastructure and reporting tools and embarked on a five-year roadmap that would include all health IT stakeholders. While this project has not

yet benefited the state and nursing homes with improved information and data exchange, there will be many lessons learned during the COVID-19 pandemic that can enhance its design and implementation.

In preparation for another COVID-19 surge, there are best practices from other states and specific recommendations that can be implemented more immediately. For example, Massachusetts had previously created an infrastructure for nursing home data reporting that allowed it to quickly pivot to collect COVID-19 data and report it on a public dashboard. The state also used these data to track and analyze key metrics (trends, staffing, PPE).

Recommendations

1. **MDHHS should clarify data reporting guidance to nursing homes and perform routine data quality and validation checks.**

    Several of the Michigan nursing homes interviewed by CHRT reported that they were still uncertain about whether they were reporting COVID-19 related data correctly to the state.

    The multiple changes in definitions since the start of the pandemic made consistent reporting more difficult for all nursing homes. Since data are self-reported by the nursing homes, it is essential that data definitions and reporting guidance be clear, with documentation and training to support nursing home staff. MDHHS IT staff also need to have the resources and tools required to manage data validation and ongoing data quality.

2. **MDHHS should expand its analytic capabilities to support targeted interventions including technical assistance and local public health services, tracking PPE and staffing shortages, and program evaluation.**

    The data that MDHHS is currently collecting could be used to better understand and target areas of greatest need when there are COVID-19 outbreaks. Data analysis (including the federally mandated Minimum Data Set) can support IPRAT's technical assistance, local public health departments, and rapid assistance for nursing homes with staff or PPE shortages.

3. **MDHHS should explore federal funding opportunities to strengthen nursing home data quality and reporting.**

    As additional federal funding becomes available, tools and training to improve data quality and reporting should be a priority area for MDHHS, if within the scope of the funding source.

Departmental and stakeholder alignment

A centralized emergency management approach that is focused on the continuum of long-term care (hospitals, nursing homes, other residential facilities, and HCBS) would serve Michigan well now in the midst of the pandemic, and be a valuable support to strengthening Michigan's system of long term care services and supports more generally.

Recommendations

1. **Communication between and within state departments needs to be strengthened, policy aligned, and implementation better coordinated.**

Michigan would benefit from reassessing its inter- and intra-state departmental coordination, communications, and policy alignment, specifically focused on LTC and managing the demands of the COVID-19 pandemic.

Several nursing homes noted that they received conflicting guidance from state and local health departments (LHD), and across LHD's from different counties. Other nursing homes mentioned that frequently changing guidance resulted in a citation for a situation that had been acceptable during one time-period and then was changed without adequate communication.

In addition, data reporting comes through several state channels and has resulted in inconsistencies between what is reported on the MDHHS website and what is reported to CMS. Better coordination of all of these resources should improve accuracy and communication.

2. **Stakeholders should continue to be engaged to ensure multiple perspectives are taken into account in the development of state guidance and policy.**

Engaging stakeholders will greatly increase the likelihood of successful implementation of policy changes. It is also important to include diverse perspectives and voices that may not always be heard such as consumer or disability advocates and community-based organizations.

Michigan routinely engages stakeholders in policy discussions. As the pandemic continues, it will be essential to maintain open communication lines and assure that stakeholders know how to raise suggestions and concerns to the department.

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