Region 1 Interagency Task Force for the Prevention of COVID-19 in the Long-Term Care Environment

Conclusions and Recommendations

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WHAT'S INSIDE

PREFACE

The devastating impacts that coronavirus disease 2019 (COVID-19) has had on the world, the nation, and the region are widely evident. Among the most vulnerable and hardest-hit populations are those living within long-term care facilities (LTCFs). Accordingly, Region I Federal Coordinating Officer Captain Russ Webster, on behalf of the Federal Emergency Management Agency (FEMA), and Region I Federal Health Coordinating Officer Gary Kleinman, on behalf of the Assistant Secretary for Preparedness and Response (ASPR), US Department of Health and Human Services, established the *Interagency Task Force for the Prevention of COVID-19 in the Long-Term Care Environment* ("Task Force"), comprising subject matter experts from a wide range of fields, to contribute specifically to combatting the spread of COVID-19 and mitigating its impacts on these residents. Under the leadership of Commander Kelly Valente, PharmD, M.S., of the US Public Health Service and Mr. David Cruickshank, M.S., EMS-I, of the National Disaster Medical System, the Task Force "hit the ground running" to meet the challenge. An additional aim in structuring the Task Force and its activities was development of a prevention and mitigation framework intended to remain in place and serve as a resource to the region beyond COVID-19 to assist with emerging issues that may impact this at-risk population. This "think tank" approach was applied to allow the group the flexibility to assist substantially without interfering with mechanisms and systems already in place. A goal of the Task Force is identifying issues, regardless of the source, that bear on effectiveness of response activities, using an exploratory process relatively free of bias, to provide regional solutions and strategies to mitigate negative impacts of the pandemic. Beyond having a positive impact on the New England region, accomplishments of the group may be more widely applicable generally and the group's activities may serve as a model for other regions, and other emergency-related domains.

INTRODUCTION

Mission Statement

Under the auspices of FEMA and ASPR regional leadership, the **Region I Interagency Task Force for the Prevention of COVID-19 in the Long-Term Care Environment** ("Task Force") is a team of federal representatives from various emergency and public health agencies that collaborate to identify and foster partnerships to provide technical guidance and support to reduce the incidence of Coronavirus Disease 2019 (COVID-19) in long-term care facilities.

Background

Since January 20, 2020, when the first case was identified in the U.S., over 4.5 million Americans have contracted severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the virus that causes COVID-19.[1] To date, more than 40 percent of U.S. COVID-19-associated deaths are linked to long-term care facilities.[2] COVID-19 spread can be reduced through active social distancing, use of personal protective equipment, and hygiene maintenance. This Task Force aims to identify gaps, coordinate activities, and offer solutions to enable stronger mitigation strategies to this complex situation facing the long-term care environment in New England and beyond.

Objectives

- Foster long-term care facility information sharing by identifying key stakeholders and data sources.
- Foster state-federal information sharing relating to the long-term care environment.
- Utilize shared information and data for action-item development.
- Identify resources that can be made available for such action items by facility-focused stakeholders for centralized and efficient coordination.

Definition

Long-term care facility: As utilized by the Task Force, a type of facility that provides a variety of services, both medical and personal care, to people who are unable to live independently; includes nursing homes, skilled nursing facilities, assisted living facilities, and group homes.

[1] COVID-19, MERS & SARS. (n.d.). Retrieved August 13, 2020, from https://www.niaid.nih.gov/diseases-conditions/covid-19

[2] The New York Times. (2020, June 27). More Than 40% of U.S. Coronavirus Deaths Are Linked to Nursing Homes. Retrieved August 13, 2020, from https://www.nytimes.com/interactive/2020/us/coronavirus-nursing-homes.html

THE PROCESS

Setting the Priorities

As an initial step, the Task Force identified the following priorities to drive the development of the specific, measurable, achievable, realistic, and timely (SMART) objectives previously stated:

- ✓ Prepare recommendations leveraged by cross-agency coordination.
- ✓ Ascertain best practices for preparation for a potential second wave or future pandemics.
- ✓ Develop a regional agency outreach mechanism.
- ✓ Ensure that Region 1 long-term care facilities have practical infection control and prevention plans with the capability to execute the plans effectively.
- ✓ Identify and reduce redundancies among planning, preparedness, and response activities.

The LEAN Model

The LEAN problem-solving method is a practical way for groups to identify the root causes of problems and propose fixes for those problems using a no-bias approach. As shown in the embedded video link, the method drills down into a problem until the process is understood and the point of occurrence is identified. Then, through asking a series of "whys," the root cause of the problem can be identified for deep corrective action rather than continually patching surface symptoms. The model is used widely by many problem-solvers, from engineers to leadership teams, and the Task Force employed it effectively to analyze problems and identify solutions.

An Open Forum

The Task Force used the LEAN method as a mechanism for open conversation regarding each of the identified topics. **personal protective equipment (PPE), infection control, staffing concerns, communication challenges, and testing/regulatory issues**. With a wealth of subject matter experts available for each of the discussions, questions posed by members of the Task Force were often addressed by other members immediately, promoting thoughtful analysis and consideration of possible recommendations. Task Force members were asked to categorize their thoughts into **local level, state level, regional level,** and **national level** recommendations. At all times, thoughtful analysis went into determining whether recommendations were **practical, actionable, and ultimately beneficial** to assisting facilities in preventing the spread of COVID-19 in the long-term care environment. In many instances, recommendations were applicable not only to addressing the spread of COVID-19 but also to mitigating other future risks to these facilities.

RECOMMENDATIONS

The Task Force agreed on the following topics, from among a wide range of possibilities, as important to address:

- Personal protective equipment
- Infection control
- Staffing concerns
- Communication challenges
- Testing and regulatory issues

The following recommendations, encompassing these topics, represent the Task Force's judgment of best practices and guidance identified by subject matter experts. Although some of the recommendations may have already been implemented in some places, to some degree, the Task Force considered them important to consider and address, in the furtherance of protecting long-term care residents and the communities of which they and their facilities are a part.

Local

- Encourage facilities to maintain a PPE supply able to last 30-60 days during normal operations, which would provide a buffer if the burn rate would increase during a time of increased risk of infection, during "all hands on deck" operations.
- Encourage participation in state healthcare coalitions to enhance the opportunity to combine resources and increase purchasing power in times of crisis.
- Refine infection control plans to address practical and effective provisions for
    - continuity of operations during potentially large reductions in staff;
    - accounting for staff being vectors for transmission into the facility, a common occurrence (rather than infection originating primarily from within the facility).
- Highly encourage the use of the 2019 Nursing Home Infection Control Worksheet developed by the Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC); not just for improvement, but for compliance.
    - Modify this document as necessary for use in other long-term care settings. The guiding principles of the worksheet are applicable to a variety of care settings.
- Ensure that guest/visitor policies are in line with best practices.
    - Restrict guest access during periods of heightened infection rates.
    - Ensure guests are screened as thoroughly as possible prior to entering. This should include signs and symptoms, any interactions with others exhibiting signs, and evaluation of recent travel at a minimum.
- Review (and revise, as needed) guidance for new admissions or returning residents and guidance for potential isolation.
- Have managers screen all entrants prior to allowing entry as some staff/visitors may be reluctant to report symptoms when reporting to work or to visit.

- Have the Infection Preventionists at each facility add COVID-19-related immunity status and immunizations to their collection of tracking data.
- Encourage facilities to increase family and/or resident representative communications. Best practices indicate that virtual town hall style meetings with facility administrators and primary staff can answer many of the general questions families have that often cannot be answered by lower-level staff.
- Provide accessible and effective communication options for patients, such as sign language and other language interpreters, closed captioning, materials in alternative formats, and assistive technology, as requested.

State

- Assist facilities that are not associated with CMS to obtain or develop similar burn rate calculators through training and education. Assist other facilities using the tool with education on increasing utilization, possibly using state or local healthcare coalitions as the outreach mechanisms.
- Encourage expansion of state/local healthcare coalitions to enhance opportunities to combine resources and increase purchasing power in times of crisis or supply shortage.
- Reformat internal data products to a common standard (such as CSV files) so that required reporting data can be more easily extracted; share any valuable insights and best practices.
- Ensure that all vulnerable populations are supported, such as those in small assisted-living facilities or group homes, with as few as three or four residents. This support includes being included in reporting data, resource provisions, inspections, and staffing support.
- Share infection-control best practices as soon as they are identified with facilities and regional partners; consider highlighting some every week.
- Explore state or federal funding options such as relief or work-force development grants to provide incentives for hiring temporary healthcare workers, with pay above what they could collect in unemployment benefits, to facilitate workforce viability.
- Identify facilities having additional challenges when implementing infection-control practices, such as Alzheimer's units getting residents to remain in compliance; work with them to help identify best practices.
- Provide incentives for facilities that increase their ratios of full-time to part-time workers.
- Work with hiring managers and educational institutions to increase the value of LTC facility work experience and patient-care hours within their own entry evaluation processes.
- Legislatively establish whistleblower protections for those reporting co-workers with symptoms and for those reporting sick-time abuses.
- Investigate critical-incident reporting and introduce requirements into legislation or regulations to make the reporting mandatory.
- Assist facilities with increased mental health resources for staff and residents. Mental health responders and resources are in short supply during times of crisis; however,

numerous programs and therapies are designed specifically for long-term care facilities and can be supplemented, such as music therapy, art therapy, and other mental health-improving activities. This may be funded through a variety of channels including state funds, public-private partnerships, and/or non-profit organizations.
- Assist in providing fit testing of respirators for CMS and state public health surveyors; the fact that many have never been fit-tested was identified as a significant deficiency.

Regional

- Encourage deployed FEMA and HHS state liaison officers to identify best practices and effective strategies to increase opportunities for sharing information.
- Determine which federal data products our state partners utilize and how they use the data.
- Commission or employ a health economist(s) to assist agencies with increased understanding of the potential benefits and overall cost savings associated with a viable infection-control program.
- Develop new certification/recognition levels that highlight compliance with infection control standards that facilities could use in their marketing material.
- Develop a matrix/grid inclusive of facility type and existing data sets for critical operational matters, such as those identified by the Task Force. This may help to identify gaps in information and that could bear on effectiveness of response. It could also provide for a visual roadmap to locations of data sets.
- Develop a "highway system" roadmap for data storage and access where users could "exit the highway" for information based on the characteristics or stage of long-term care they are addressing. For example, assisted living facilities require data and information sets that differ from those of skilled nursing facilities. One of the biggest problems during the outbreak was seemingly conflicting information. Some of this information was not actually conflicting, but was meant for different audiences. The apparent conflict may have eroded trust in information sources.
- Facilitate the deployment of personnel to provide technical advice on infection control and PPE guidance in times of need.
    - Inform these advisors about common pitfalls as identified by quality improvement organization (QIO) surveyors.
    - Emphasize best practices and technical assistance over enforcement and citation.

National

- Add a regulatory component requiring facilities to have a minimum 30-day (ideally 60-day) supply of PPE on hand during normal operations (consider including in CMS regulation).
- Consider allowing state or local healthcare coalitions to hold the same preferential status as states, to procure constrained resources, in order to ensure availability of supplies so that facilities can order needed supplies prior to the general public.

- Expand the existing data reporting infrastructure to allow for a unified reporting mechanism that will bridge gaps and simplify the process.
- Provide for the ability for states to use funding, as part of any federal aid package, to provide incentives for long-term care facility staff to earn more than if they were to collect unemployment benefits.
- Provide research grants for the purpose of investigating and highlighting the potential benefits and overall cost savings associated with well-managed and viable infection-control programs.
    - This research could also delve into other areas of infection control and preparedness to benefit LTCFs.
- Identify ways to resume nurse aide course funding which was funded primarily with citation revenue and significantly cut due to the focus-shift of inspections.
- Investigate potential future stimulus money to be earmarked for cost-share programs with LTCFs investing in the safety of their staff and residents by bringing in temporary, emergency housing in order for staff to remain safely onsite.
- Work to increase unified messages presented by elected officials and scientific organizations, which has broad implications ranging from facilities to families and residents.
- Develop a national platform and clearinghouse for information regarding long-term care facilities, similar to the web-based system currently used for hospital data, to potentially simplify data reporting and access to data during critical times.
- Develop a "satisfaction with facility-to-family communications" metric to be used to establish a new, attainable goal for facilities.
- Increase resources for mental health support for long-term care facilities. The mental health impacts are substantial when residents are unable to leave their rooms or facilities, or to see their loved ones. For example, increasing funding for mental health-improving programs such as art or music therapy would greatly benefit these facilities.
- Consider increasing funding to Medicare and Medicaid to make meaningful changes in the long-term care environment that could stem future disasters.
- Increase funding for infection-control training for inspection staff and surveyors.
- Review options for bonuses or increases in reimbursements for facilities that are leading the way with their practices.
    - Emphasize incentives over penalties.

APPENDIX A - THE THINK TANK TEAM

As many Task Force members were deployed to Region 1 for the COVD-19 response, both the deployed role and the steady-state role of each Task Force member are indicated below.

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APPENDIX B – Discussion Notes:

- ***Discussion on Personal Protective Equipment (6/29/2020)***
  - A breakdown of PPE shortages by facility-type might be helpful to see whether gaps in reporting or gaps in PPE coverage exist for at-risk populations.
  - Address the complexities of the inverse ordering pyramid ranging from private facilities, state, and federal government implication on purchasing power and access to ordering.
  - Increase the role of state-level healthcare coalitions to support facilities in purchasing, and strengthen the system. New Hampshire is a great example of how this is working well.
  - Identify strategies to address the delicate balance between stocking and supplying. For example, the VA has used a fairly successful model since the H1N1 crisis of keeping a 30-day rotating stock for all PPE and medications, and has recently upped this disaster contingency to 60-days.
  - Concern was raised about civil rights cases regarding certain facilities not being classified as long-term care facilities eligible for these PPE distributions, such as group homes.
  - Burn-rate calculators can be biased by surge patient counts or PPE usage that may be outside of normal use rates. It could be beneficial to develop an assistance tool to help facilities with inventorying with items such as the type of assessment utilized and level of confidence in tool accuracy.
  - Expand educational opportunities for facilities on proper burn-rate calculations beyond just ordering and methods recognized to help slow the burn rate such as PPE re-use.
  - Increase staff education on the proper use of PPE. For example, the VA has provided staff to assist facilities and a common theme identified involves the staff at facilities are not being properly educated about PPE.

- ***Discussion on Infection Control (7/6/2020)***
  - The pilot 2019 Nursing Home Infection Control Worksheet developed by CMS and the CDC has been utilized more frequently and is recognized as more than just a worksheet; it is a roadmap for being in compliance.
  - The severity of the consequences of infection control could play a role in gaining compliance, ranging from education and submission of a plan to fix the offense, all the way to thousands of dollars per day in fines, or even termination of federal assistance. Statements of deficiencies are public documents and visible on websites such as Nursing Home Compare, and can affect ratings and ability to conduct business. For this reason, facilities take inspections seriously and typically work to correct any identified deficiencies.

- A streamlined version of the aforementioned worksheet could be produced specific to COVID-19 (may already exist).
- Facilities have varying levels of sophistication in infection control; strategies to "level up" the field should be identified.
- An updated version of the pathway specific to COVID-19 on the CDC website has similarities to and differences from the CMS pathway worksheet. The CDC also has a preparedness checklist that walks through the guidance.
- Factsheets have been helpful with information changing daily. Identify current factsheets and update as needed with listing of resources for facilities to utilize.
- A refined decision guide and Immediate Corrective Action Required (ICAR) tool would be beneficial. CDC links typically remain the same while the content is continually updated.
- Facility re-openings pose a challenge, since guests and staff are not always screened equally, and substantial transmission has been through staff, resulting in multiple citations.
- Important knowledge is that poor infection control costs more to a facility in the long run than a well-regulated, viable program. Staffing records show frequent staff movement due to low staff numbers or various overtime assignments between COVID-positive and COVID-negative units. This poses a problem.
- Consider the impacts not only of medical staff traveling between units and facilities but also that many employees work in multiple facilities and may not be screened sufficiently.
- Staff employed by a single facility typically have more control over their possible exposure than those working in multiple facilities.
- Employing a health economist can be helpful, at the state, regional, or federal level, to help agencies understand the potential benefits and overall cost savings associated with having proper infection control programs, affecting the long-term financial viability of a facility.
- Pending funding availability, commissioning a research study specifically on this topic could be beneficial to the nation and help facilities see the benefits.
- State nursing home associations might be an excellent, existing resource for pushing out information and best practices.
- Most LTCF infection-control plans currently rely on an assumption of full staff availability and participation. Lack of validity of this assumption was a substantial issue during the first wave of COVID-19.
- Introduction of the infection to nursing homes has been through staff; this is a separate consideration from that of infection spreading from the inside.
- Challenges with infection control plans may be outside the scope of COVID-19. The types of individuals within a facility could dramatically affect their infection control plan. For instance, a dementia or Alzheimer's unit could have significant

challenges if the residents won't tolerate wearing a mask for long periods of time. The identification of best practices in this area would be beneficial.

- Infection-control plans need to account for new admissions and those transferring settings. Residents have rights to their belongings and "home settings." For example, a return transfer from a dialysis center could be dramatic if a resident is relocated upon return.
- Due to COVID-19, costs are going up in the form of medical treatment expenditures, alternative staffing, bonus pay for staff, etc., and as a result nursing homes are forced to accept new residents to increase revenue. The increase in resident population and the added challenges of absenteeism is a recipe for infection outbreaks.
- A recent story by the Associate Press (Appendix C: NY Count: 6,300 virus patients sent to nursing homes) highlights that outbreaks are directly tied to an increase in patients/residents. This story recounts the movement of recovering patients from hospitals to nursing homes. In already resource-depleted environments the influx of new residents degrades conditions at the facilities. A potential solution may include legislation that allows LTC facilities to lock down patient intake, without saddling them with insurmountable expenses for the care and treatment of existing residents.

➢ *Discussion on Staffing Concerns (7/13/2020)*

- Staff members are reluctant to report having symptoms, even when asked, due to the risk of not being allowed to work. Low salaries contribute to this issue, due to the enhanced importance of continuing paid work.
- Statistics on facility employment numbers for full-time and part-time employees would be interesting. Some facilities reportedly hire more part-time employees to avoid paying full-time employee benefits. This may lead people to work for staffing agencies to get full-time benefits. As previously noted, these staffing agencies are typically responsible for staffing multiple facilities.
- A paradigm shift may be important with respect to the work environment. Attractiveness of the work affects recruiting. A hierarchy is perceived in healthcare, with hospital work high and LTC facility work low. Consideration of how this can be shifted may be useful, with consideration of benefits, hours, and other aspects. The career progression for LTC facilities may merit consideration. For example, EMS is often a starting place for those entering the medical field, how can we make LTC facility work be made more attractive to those starting their careers in the medical field, as a possible stepping stone to other medical careers?
- Review of data on punitive work records related to the wellness of the workers may be informative. Are staff disciplined rather than rewarded for avoiding work among a vulnerable population when they are sick? Whistleblower protections

may be useful for those reporting others showing symptoms or abusing sick time.

- Concern is associated with nurse aide training being suspended due to COVID-19. CMS funds a large portion of nurse aide training. Due to multiple factors, including the challenge of safely holding these trainings in the COVID-19 environment, this training has been temporarily suspended, adding to shortages.
- Financial burden to facilities due to COVID-19 is complex, as noted in numerous news articles, including that bed counts are down, resulting in lower income for facilities, causing further complications.
- Discussions are taking place at many facilities with family members who are nervous about the care levels or future lockdowns if a second wave occurs. Many are considering other care solutions for the short-term, such as in-home care. This could exacerbate a reduction in bed count.
- Many rehabilitation facilities are facing reductions, as surgeries such as hip and knee replacement are being rescheduled. In some instances, patients in these beds are being replaced with recovering COVID-19 patients, which receive very different care.
- A matrix/grid might be useful to many, from researchers to legislators, to identify gaps and issues in long-term care. The matrix could associate facility type, on one axis, with topics considered by the Task Force (PPE, staffing, infection control, etc.), on the other axis.
- Risk factors associated with LTC facilities have been the subject of research, including staff, patients, socio-economic status, race, gender, and other factors. Data presented showed that a high percentage of staff are minority, women, over the age of 50, or black/non-Hispanic.
- Statistics indicate a high proportion of LTC staff deaths. Many have been unreported. While facilities are reporting, less clear is whether staffing agencies or group homes are reporting numbers.
- No reporting requirements are mandated in pending legislation.
- Task Force recommendations need to be sensitive to the facilities' perspectives as reported in the media, such as "this legislation is going to kill us." Recommendations should account for costs that may be involved and could be imposed. We need to support positive changes and not hinder progress by insensitivity to facilities' needs.
- A recommendation is warranted to have the infection preventionists at long-term care facilities track staff immunizations, to know immunity statuses of their employees as it becomes available. They are already mandated to track influenza and pneumococcal vaccines among the staff, although such immunization is not required. This type of tracking would, in theory, be easy to add to their current vaccine tracking role.

- As mentioned in the NY Times opinion piece *"The Coronavirus is Killing Too Many Nursing Home Residents*," if an emergency cost-share program could be implemented to help facilities provide on-site, emergency housing for staff, infection control could be dramatically improved. As mentioned in the piece, this could save a significant amount of lives and pay for itself in the form of reduced lawsuits.
- The possibility should be considered that the CARES Act federal stimulus money may have, in at least a few situations, influenced LTC facility workers to seek unemployment benefits instead of reporting to work. Potentially this could be remedied with enhanced family care and compensation through the HEROES bill or one akin to it.

➢ *Discussion on Communication Challenges (7/20/2020)*

- A communication challenge highlighted in the media is inconsistencies between messages of elected officials/politicians and messages of scientific organizations and experts, including those working in the government. This challenge affects views and perceptions of a wide range of people, from state partners to residents and family.
- Many facilities face technological issues regarding virtual visitation and contact with the outside world. Many residents do not have devices or are unable to effectively use assistive technology.
- The impacts of the cognitive status and level of understanding among residents needs to be addressed. Some residents do not understand what is happening and why. An increase has occurred in the number of elopements of residents trying to leave facilities or wandering away. This can be tied to their cognitive levels and lack of contact with family members who are not able to intercede.
- Challenges are associated with protective measures regarding requirements for accessibility, with effective communication, and with the need to provide communication options for patients, such as sign language and other language interpreters, closed captioning, materials in alternative formats, and assistive technology, as requested.
- A data roadmap may be useful, with what information is collected, by whom, accessible to whom, and where that data is housed. HHS Protect is working on becoming the clearinghouse for all hospital-related data with groups such as NHSN. What information and data is being included regarding LTC environments is unclear, as is whether plans exist for a national clearinghouse for that data.
- An information roadmap will need to take many things into account such as different pots for data. Data requests by regional health organizations will look a lot different than the data provided to families. It will depend upon who the customer for the data is. Some of this is already being done such as the CMS open data accessible for families.

- Different roadmaps may be needed for different customers, for instance families, healthcare coalitions, etc. People also change trajectory throughout life such as moving from assisted-living to a nursing facility.
- Increased outreach to families is needed. More-than-the-usual number of complaints have been coming into CMS from families who feel they are left in the dark about facility activities; they feel disconnected. During extraordinary times, the facility may serve better by taking initiative to reach out to families and/or representatives of residents.
- Veterans Health Administration nursing homes have been holding highly successful, regular, online town meetings for the veterans' families with the facility director and primary staff. They are able to answer a lot of the questions families have had, as well as ones they may not have thought of.
- The Nursing Home Compare website is an effective way to stimulate positive change. This is a five-star rating system for facilities; facilities are concerned about their ratings on this site because the rating can sway potential residents either toward or away from their facility. A metric of "satisfaction with facility communication with families" could provide emphasis on this criterion.
- Standards of practice are different from best practices. If a standard of practice is established, for instance family communication, it can be tied back into the regulations by whether or not a facility is meeting the standard of practice. This could be a way to implement a regulatory-like change more quickly than establishing an actual regulatory change. If a state-level nursing home association implemented a standard or a standard was published in a peer-reviewed journal, these could then become considered standards of practice.
- Communication issues impact residents in other ways as well. A serious need is to increase the activities for residents that keep them cognitively engaged, such as those that include substantial sensory stimulation.
- Social stimulation is different from cognitive stimulation and we need to be aware of how social isolation affects different populations. For example, school children are learning to cope with social isolation while residents of LTC facilities may not be able to adapt easily.
- Social distancing has severely impacted facilities. The inability to leave the room, lack of communal dining, decrease in the number of activities, and lack of visitation from outside groups or entertainers are all challenges. These are also challenging in the virtual environment.
- An uptick is occurring, sadly, in people giving up their will to live. Drastically limited interaction appears associated with weight loss and other detrimental effects. Families are concerned about their loved ones. Some facilities are only able to offer a 20-minute visit per week in order to accommodate all the residents; this is not enough outside contact for some residents.

- Mental health responders are important, such as those with HHS. While they may be assisting in this area, a clear need exists for this type of response capability to be ramped up.
- Ageism is sadly coming to light through this crisis. Public perception of those in nursing homes is that they are "waiting to die" and that relatively few years of quality life are left. The media focuses on younger populations such as school children, and older residents are often overlooked.
- Even in the best of times long-term care facilities may be looked down upon. A lot of work CMS does is to ensure that these facilities are not just "warehousing the old," but are treating people with the dignity they deserve. Obviously, there is always room to do better.
- With everything we have discussed, we have to remember that costs are associated with these recommendations. Previous levels of funding likely will not be able to pay for many of them. Sadly, the question ultimately to be raised is whether America is ready to increase the funding to Medicare/Medicaid and improve the conditions in these facilities. Many larger issues and questions arise. After any increase in funding or temporary assistance, will it revert back? Making life better for older citizens costs money.
- Public/private partnerships might be able to help fund change.

➢ *Discussion on Testing / Regulatory Issues (7/27/2020)*

- Results of antibody tests need to be interpreted cautiously with respect to preventative considerations. Scientific data are not yet available regarding the establishment of immunity associated with recovery from infection and having antibodies, nor regarding the duration of immunity in relationship to the presence of antibodies.
- A substantial issue currently is that asymptomatic visitors and staff are bringing the infection into facilities, causing its spread.
- The group discussed if a need exists for an increase in regulatory inspection funding. State surveyors are carrying the bulk of the weight and all other surveys have been put on hold in favor of infection-control surveys. The number of surveyors is particularly limited due to health concerns. Many of those eligible to retire have opted to do so and some of those that remain have cited personal health concerns for not doing inspections. Training and the time to get a surveyor up to speed take almost two years.
- Two different approaches are pertinent here. The first is the regulatory model. This should be the floor to ensure that the basics are put into place; the minimum. The second is everything else that works to raise the floor and improve the conditions of the room. For the most part, this doesn't require regulatory citations. These should be the safety check and not the first line. Facilities in crisis need technical assistance, not citations. The survey process is

for minimal standards. Surveyors are not allowed to consult when at a facility for legal and conflict of interest reasons. Consulting can really help, and that is where the QIOs have been stepping up. They have been offering best practices and infection control strategies. They are funded by CMS and are the quality assurance arm of the surveys.

- Disaster Medical Assistance Teams have been working to help facilities with technical assistance. Can we take the inside knowledge of QIOs to help develop a stronger infection-control strategy and best practices tool?
- We have to be careful in developing guidance and instruction programs, as they can be open to interpretation. A base level of understanding exists, but understanding may be limited of crisis standards for PPE, interpretation of testing results, etc. Many pathways are possible for getting strategies and best practices to facilities. Some work is duplicative, but important work is largely getting done.
- A "do-it-yourself" guide for facilities, potentially to be supplemented by technical advisors, could be helpful if it addressed all of these concerns. It could be a low-cost way to for facilities to boost performance. This could also eventually develop into a standard of practice that would be enforceable.
- The Task Force agreed that an emphasis on best practices and technical assistance over enforcement makes sense. Faster and more productive results may be gained from guidance as well as a lack of nervousness of being cited.
- Fit testing seems to have been a roadblock for many surveyors early on and even currently. Many surveyors had never been fit tested prior to the outbreak of COVID and many still have not.
- An increase in funding for infection-control training for inspection staff would be useful.
- Guides on PPE preservation specific for LTC facilities, and education surrounding that could be useful. The Healthcare Resilience Working Group has produced a PPE Preservation Planning Toolkit to foster implementation of preservation practices, as well as awareness of the impact on PPE supply duration of doing so.
- The Task Force discussed, without definitive conclusion, what was being done as far as quality bonuses and reimbursement increases for high-performing facilities. An emphasis on incentives over penalties may be prudent and efficient during the emergency. Several avenues for this may be available, including Medicare part A and various Medicaid programs for reasonable measures. These could provide incentives for facilities.

APPENDIX C - Resources

External Links:

- Nursing Homes and Covid-19 (6/2020)
- Guidance for Relaxing Communal Dining and Activity Restrictions for Assisted Living Residences (6/18/20)
- ACL – Aging, Independence, and Disability Program Data Portal (2020)
- 2019 Assisted Living State Regulatory Review (2019)
- COVID-19 Rapid Response Network for Nursing Homes – Daily Webinars
- COVID-19 Resources for Nursing Homes & Long-Term Care (Updated regularly)
- Coronavirus (COVID-19) Advice for the Health and Aged Care Sector (Australian Government)
- OSHA-FEMA Region 1 COVID-19 Virtual Guide – A Compendium of Guidance (2020)

Centers for Disease Control and Prevention Guidance

- Preparing for COVID-19 in Nursing Homes – CDC.gov (5/19/20)
    - Performing facility-wide testing in nursing homes
    - Considerations for Memory Care units in LTCFs
    - Responding to COVID-19 in nursing homes
    - Testing guidelines for nursing homes
    - Infection prevention and control assessment tool
- COVID-19 Preparedness Checklist for Nursing Homes and other Long-Term Care Settings
- Optimizing Supply of PPE and Other Equipment during Shortages

Centers for Medicare and Medicaid Services Guidance

- Long Term Care Infection Control Self-Assessment Worksheet
- Current Emergencies Page
    - Nursing Home Reopening Recommendation FAQ (5/18/20)
    - Toolkit for States to Mitigate COVID-19 in Nursing Homes (5/13/20)
    - Guidance on Notification Requirements of Confirmed and Suspected COVID-19 Cases Among Nursing Home Residents and Staff (5/6/20)
    - COVID-19 LTCF Transfer Scenarios (4/13/20)
    - COVID-19 Long-Term Care Facility Guidance (4/2/20)
    - Guidance for Infection Control and Prevention of COVID-19 in Nursing Homes (REVISED) – (3/13/20)
    - Guidance for use of certain industrial respirators by health care personnel (3/10/20)