Great Lakes
Health System of WNY

COVID-19: The Impact on Long-Term Care Facilities

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Current State of COVID-19 in Post-Acute Care

COVID-19
Post Acute Care

- NYS DOH dictates level of care management for COVID19 patients who cannot discharge home from the hospital.
- Bed management needs to be optimized to assure patients are efficiently placed in the most appropriate, least restrictive level of care.
- Best practices for optimal recovery in patients who have had a functional decline due to hospitalization from COVID-19 includes early mobilization and directed therapies to regain function.
- All facilities in the care continuum need to have processes in place to identify, monitor, cohort and manage patients across the COVID-19 spectrum of disease.
- Cooperative management to allow for optimization of patients in place allows for optimal bed management across the care continuum.

COVID-19
Bed Management Goals

- Referral patterns should reflect facilities exhausting reasonable care in their facilities before escalation of care to inpatient hospitals.
- Referrals ***from*** the hospital to LTCFs should proceed efficiently.
- The hospital will evaluate and appropriately screen patients and determine the patient is medically stable for transfer.
- Patients will be tested for COVID-19 as clinically indicated.
- Patients who are COVID19 positive in the hospital, can only be transferred to 2 sites in Erie County for post acute care.
- Historically, 25-30% of inpatients required skilled, facility-based post acute care.

COVID-19
Bed Management Goals

- Moderate and large platform nursing facility operators must develop COVID-19 dedicated units, isolation units for transitioning new admissions to their facilities and cohort patients to keep long term units as isolated as possible from COVID exposure.
- Independent facilities and small platform operators should develop strategic relationships with community partners to manage COVID-19 patients and allow cohort by disease status.
- "YELLOW" units allow for non-COVID-19 patients to be transferred to congregate living facilities. These units involve serial testing strategies, isolation of new facility patients and risk stratification and symptom tracking to assure patients who develop clinical changes are identified early and tested appropriately to allow disease specific cohort.

COVID-19
Bed Management Goals

- "RED" units allow for COVID-19 patients to be grouped in cohort with other positive patients. Staff is restricted to this unit to avoid cross contamination and Enhanced PPE strategies with full droplet and contact precautions are employed. These units also involve serial testing strategies, to allow for identification of patients who have recovered from COVID19 and cleared viral RNA from their nasopharynx.
- "GREEN" units allow for non-COVID-19 patients to be transferred to units within their facility where all the residents have been identified as COVID negative and asymptomatic, with no risk of exposure. Symptom tracking and employee testing continues as per State guidelines and universal masking with all patient encounters for staff remains in effect.
- All visitation has been suspended and this remains in effect to limit the risk of unnecessary viral exposure.
- Additionally, adult congregate living facilities are required to test all employees and medical staff contractors or volunteers; twice weekly. Any employee who tests positive is restricted from work for 14 days and must have a negative test result before they can return to the facility.

COVID-19

Infection Control and Prevention Practices

As care pertains specifically to COVID-19, state and federal rules and regulations require nursing homes adhere to appropriate safety measures including, but not limited to:

- Restricting visitation at all nursing homes and adult care facilities, except for imminent end-of-life situations.
- Provide personal protective equipment (PPE) for staff at all nursing homes and adult care facilities, including surgical-grade facemasks, gloves, gowns, and eye protection (e.g., goggles or face shield) when interacting with COVID-19 suspected or confirmed residents. Staff must wear at least a facemask during interactions with all residents.
- Requiring all staff to be checked for COVID-19 symptoms (e.g., fever, cough, difficulty breathing, or other respiratory symptoms), including temperature checks upon the start of each shift and every 12 hours while on duty.
- Requiring testing of all staff on regular intervals. (Weekly for CMS standards and twice weekly for NYS DOH requirements.)
- Requiring facilities to notify all residents and their family members within 24 hours if any resident tests positive for COVID-19 or any resident suffers a COVID-19 related death.
- Having protocols to separate residents into cohorts of positive, negative, and unknown as well as separate staffing teams to deal with COVID-positive residents and non-positive residents. In order to effectuate this policy, nursing home facilities should transfer residents within a facility or to another long-term care facility; if they are unable to successfully separate patients within a facility.

COVID-19
State of the Space

- Erie County, NY has 35 nursing facilities with capacity for 4,484 residents.
- Prevalence is 16% across these facilities as a whole with 724 COVID-19 positive patients as of 6/2/2020.
- Cooperative, community solution for dedicated COVID-19 SubAcute Rehabilitation unit was developed in March 2020.

COVID-19
State of the Space

- 6 facilities with capacity for 1,137 residents came together to create a specific COVID-19 unit to manage patients in congregate living facilities and from inpatient transfers.
- Prevalence in this cooperative approach is just **1.76%.**
- Across these 6 facilities, more than 75 COVID-19 patients have been managed in the dedicated unit and over the last 10 weeks, less than 5 fatalities have occurred in all six of these facilities, related to COVID-19.

COVID-19

Clinical Management of Recovering Patient

COVID-19 presents in several different patterns in the population.

- Primarily respiratory symptoms
- Non-respiratory
- Asymptomatic but SARS COV2 detectable RNA

COVID-19

Clinical Management of Recovering Patient

- Primarily Respiratory Symptoms
  - Supplemental oxygen via NC or mask
  - Vitamin C 2000-3000 mg daily in divided dose
  - Vitamin D supplementation daily
  - Frequent repositioning
  - Nebulized beta agonists
  - Steroids in patients with co-morbid conditions that previously responded to steroids

COVID-19

Clinical Management of Recovering Patient

- Non-respiratory symptom complex
  - Patients are assessed for appetite deterrent.
  - Nausea managed aggressively.
  - Mood optimized when contributing to anorexia.
  - Modified consistency diet in dysphagia.
  - Aggressive SLP to optimize swallowing.
  - Vitamin C 2000-3000 mg daily in divided dose.
  - Vitamin D supplementation daily.
  - Protein and calorie supplementation provided.
  - IVF when electrolyte or renal function warrants.
  - Early physical mobility and therapies to improve function.

COVID-19

Clinical Management of Recovering Patient

- Asymptomatic but SARS COV2 detectable RNA
  - Vitamin C 2000 mg daily in divided dose.
  - Vitamin D supplementation daily.
  - Routine mobility support with PT, OT and SLP as appropriate to maintain functional level.
  - Close monitoring with risk stratification and symptom scoring.
  - Geriatric population has shown a variable disease presentation and delayed symptom onset.
    - Reports suggest up to 14 day to symptom onset but we have seen up to 4 weeks for symptom onset in this population.
  - Can have delayed viral clearing from nasopharynx.
    - We have seen asymptomatic patients remain SARS COV2 RNA detectable in NP swabs for 7 weeks from initial positive swab.

COVID-19

Post Acute Challenges

- Taxing an already under-resourced clinical space
  - Financially
  - Human Resources
  - Resident emotional and psychosocial well being
  - Resident physical well being

COVID-19
Post Acute Challenges

- Financial implications
  - Post acute facilities functioned on very narrow margins before COVID19
  - COVID19 eliminated elective surgery and reduced non-COVID referrals by nearly 75%.
  - Community referrals to this level of care essentially stopped.
  - The cost of PPE for facilities to appropriately address cohort management adds nearly $10,000/month for each unit that is designated YELLOW.
  - The cost of PPE for a facility to manage a RED unit is nearly double that.
  - The mandate to test all staff, twice a week, adds a cost of approximately $150/week/employee to the facility expenses. This is not covered by health insurance and if the employee refuses to be tested, they are not allowed to work. A 100 bed facility, has on average 200 employees. This means the facility will spend $30,000/week for testing.
  - That is $1,560,000 annually if the testing were to continue. On average, a facility that size would have been expected to have approximately $1,000,000 annual operating surplus before COVID. The cost of employee testing ALONE, negates any expected profit and puts the facility at a loss, before considering PPE and lost revenue from reduced admissions.

COVID-19
Post Acute Challenges

- Human Resources
  - Nursing facilities have historically been understaffed and with limited resource pool.
  - Staff have been reluctant to work in a facility or with a COVID positive patient.
  - Staff often work in more than one facility
  - With mandated testing requirements, potential to lose up to 20% of workforce with asymptomatic positives or employees who cannot afford the unfunded mandate for serial testing is significant.
  - Significant psychosocial strain placed on caregivers in this space.

COVID-19

Post Acute Challenges

- Resident emotional and psychosocial well being.
  - Visitor restrictions went into effect in March.
  - Residents who relied on family and friends have lost that contact.
  - “Tele” visits for social interaction in this population subset has been less effective than for other generations.
  - Family advocates have not been able to be as engaged.
  - Relationships between facilities and families that had been strengthened by allowing family access to the facility and staff have been strained by the imposed lack of access, challenging these relationships.

COVID-19

Post Acute Challenges

- Resident physical well being.
  - Congregate adult living poses the highest risk for mortality from COVID.
  - Poor infection control practices almost exclusively account for faculties that have high mortality and prevalence.
  - Facilities have reported over 90% prevalence in an outbreak and mortality in congregate living facilities can account for 50% or more of community deaths in some areas.
  - Reports of 30% mortality within a facility have been noted.

COVID-19
Post Acute Care

Thank you for the opportunity to share my experiences. I welcome any feedback.

- Questions, comments or concerns:
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