



American Geriatrics Society Policy Brief: COVID-19 and Nursing Homes

American Geriatrics Society

This policy brief sets forth the American Geriatrics Society's (AGS's) recommendations to guide federal, state, and local governments when making decisions about care for patients with coronavirus disease 2019 (COVID-19) in nursing homes (NHs) and other long-term care facilities (LTCFs). The AGS continues to review guidance set forth in peer-reviewed articles and editorials, as well as ongoing and updated guidance from the Centers for Medicare and Medicaid Services, the Centers for Disease Control and Prevention, and other key agencies. This brief is based on the situation and any federal guidance/actions as of April 4, 2020. It is focused on NHs and other LTCFs, given their essential role in addressing the COVID-19 pandemic. *J Am Geriatr Soc* 00:1-4, 2020.

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This policy brief sets forth the American Geriatrics Society's (AGS's) recommendations to guide federal, state, and local governments when making decisions about how best to care for patients with coronavirus disease 2019 (COVID-19) in nursing homes (NHs) and other long-term care facilities (LTCFs). The AGS continues to review guidance set forth in peer-reviewed articles and editorials, as well as ongoing and updated guidance from the Centers for Medicare and Medicaid Services (CMS), the Centers for Disease Control and Prevention (CDC), and other key agencies to inform AGS policies and recommendations.¹⁻³ This brief is based on the situation and any federal guidance or actions as of April 4, 2020. It is focused on NHs and other LTCFs, given their essential role in addressing the COVID-

19 pandemic. Governments, healthcare organizations, and health professionals all are facing challenges that must be addressed for the safe, person-centered care of the overall population.

WHY IT MATTERS

More than 15,000 NHs (also referred to as skilled nursing facilities and LTCFs) care for the oldest and most chronically ill Americans, who are the most susceptible to COVID-19 and its complications, including respiratory failure and death.^{4,5} As the COVID-19 pandemic continues to unfold, several challenges will impact care across these settings.

There is an inadequate supply of personal protective equipment (PPE) to care for residents with COVID-19 and those suspected of having the disease, further compounded by a shortage of tests. Given asymptomatic shedding, PPE ideally is available when caring for all residents. PPE not only protects the care staff but also the resident. Without these tools, many other unnecessary outbreaks, such as the one in the state of Washington and others that have been reported, will likely occur—possibly with high mortality rates.⁶

NH residents are not only the most vulnerable to complications and mortality from COVID-19 but also may not have typical symptoms of the disease. One NH in Massachusetts tested all 98 residents without any symptoms in preparation for transferring them and making the NH available to COVID-19 patients from their affiliated hospital. Fifty of these residents without symptoms tested positive (personal communication to a member of the writing group). Many other NHs across the country are reporting COVID-19–positive residents with no or atypical symptoms. Thus, it is impossible to determine with clinical certainty whether a resident has the disease without testing, which still may yield inaccurate results due to a higher-than-normal likelihood for false-negative results.⁷

To compound this clinical challenge, NH staff may pass mandatory symptom and temperature screening procedures and still be infected, shedding enough virus to infect residents and other staff.⁸

Further, many hospitals across the country are already overwhelmed with patients who have COVID-19, and more hospitals are likely to experience similar demand in the

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coming months as the virus spreads. Early steps taken by health systems included suspending elective surgeries and discharging those patients who could be safely sent home or to another site of care, including NHs.^{9,10}

For long-term care, CMS has taken several important steps, outlined in its official guidance for NHs.¹¹ Several proactive states already grappling with significant COVID-19 cases are focusing attention on increasing the number of available beds for patients with COVID-19 while maintaining capacity for other conditions requiring hospitalization. NHs and other LTCFs have focused on steps to protect current residents. These include heightening infection control, banning visitors, and eliminating all group activities.^{2,12} Despite these early efforts, many NHs are reporting infections among residents and staff. Most states not yet in crisis are actively planning across multiple domains. Efforts underway include developing plans to ensure that community-dwelling older adults have access to the services they need and planning for the conversion or development of alternative care sites that can focus on care outside the hospital and NH setting for patients with COVID-19.^{13,14} In some communities, NHs may contribute to these efforts by converting to COVID-19-only facilities or using separate units with separate staffing for this purpose.

As we have learned across many healthcare settings to date, outbreaks in NHs and other LTCFs are a foreseeable consequence of this pandemic, even when facilities and health professionals work valiantly and follow all guidelines. While some of this inevitability may be due to circumstances we can work to control—including the lack of available PPE and testing—other challenges remain beyond our control. The coronavirus responsible for COVID-19, for example, is highly contagious even when patients are asymptomatic, and NH residents are among the most vulnerable people given that they often have multiple chronic conditions. For residents with dementia (who constitute 47.8% of the NH population nationwide), following best practices will be particularly challenging.¹⁵

RECOMMENDATIONS

CMS has rolled out several policy changes to support healthcare professionals and systems on the frontline of caring for individuals with COVID-19. These include changes in how Medicare reimburses for telehealth visits and updates to eliminate the 3-day hospital stay rule to allow Medicare to cover earlier admissions to NHs.^{16,17} Additional guidance and policy changes will be necessary to protect the vulnerable NH population, as well as the health professionals and direct care workers who care for them.

Issue 1: Defense Production Act and Supply Chain

Defense Production Act

We appreciate that the President has invoked the Defense Production Act to increase the supply of ventilators. However, there are current and potential shortages of equipment and supplies across settings. NHs, LTCFs, other congregate living settings (eg, assisted living), and home healthcare agencies (eg, Visiting Nurse Association) must be included as priorities when estimating what is needed for America's

coordinated response to COVID-19. The existing and future shortfalls will only be addressed if the President fully exercises his authorities under the Defense Production Act so that we can move quickly to increase production and distribution of:

- *PPE*: This includes the masks, face shields, gowns, and gloves that all frontline healthcare professionals and direct care workers need to protect themselves against becoming infected. PPE protects health workers' own safety, which is key to ensuring we have access to the healthcare workforce we need during this pandemic.
- *Testing kits and related laboratory supplies*: Supplies for diagnostic and serologic testing are integral to protecting the health and safety of all Americans during a pandemic.
- *Supplies for symptom management and end-of-life care*: The federal government should proactively monitor the available supply of medications (including opioids) and equipment commonly used in symptom management and at the end of life, particularly for people who develop the distressful and uncomfortable symptoms of respiratory failure. If shortages are imminent, the President should fully exercise his authorities under the Defense Production Act to prevent a gap in the supply of the medicines and equipment critical to symptom management, especially at the end of life.

Supply Chain

The Department of Defense (DoD) has significant expertise and the requisite equipment to coordinate the supply chain with state and federal governments. The President should authorize the DoD to work with the federal and state governments to (1) coordinate the sharing of scarce resources within and across states; (2) deliver new resources to states and communities; and (3) help to prioritize NHs, LTCFs, other congregate living settings (eg, assisted living), and home healthcare agencies (eg, Visiting Nurse Association) for the tools and resources they need.

Issue 2: Safe Transfer of COVID-19 Patients

For individuals who test positive for COVID-19 or are strongly suspected of contracting the disease, several important factors will impact transitions between care settings:

Hospital to NH

Individuals who test positive for COVID-19 should not be discharged to a mainstream NH unless the facility can safely and effectively isolate the patient from other residents and has adequate infection control protocols and PPE for staff and residents. This includes the ability to isolate or cohort the resident(s) separately from the rest of the community and provide dedicated staff for people with COVID-19. Such transfers should be in accordance with current CDC guidance.

NH to Hospital

The CDC should develop guidance regarding transfers to an emergency department for residents presumed or confirmed to have COVID-19. Factors to consider are (1) whether the resident's goals of care have been discussed, including completion of a Patient Orders for Life-Sustaining Treatment or advance directive; (2) what the resident's medical needs are, as determined by the NH clinical staff and attending physician; and (3) whether the NH will be able to provide the resident's medical care in place.

Issue 3: Public Health Planning

Public health planning will necessitate coordination with several important stakeholders and across several different priorities:

- **Geriatrics health professionals** should be recruited to serve on pandemic response and planning teams, given their expertise in caring for older people with advanced illness, leading interprofessional collaboration, implementing knowledge of long-term care across settings and sites, and leading advance care planning. This unique skill set is essential for community-level planning.
- **NH leadership teams** (eg, administrators, medical directors, and directors of nursing) are vital resources for planning how NHs can best be deployed during the COVID-19 pandemic. These teams have expertise in allocating resources within their own facilities; developing community-wide plans in collaboration with acute care hospitals and other post-acute care institutions in their communities; and building understanding of staffing needs, as well as federal and state regulations.
- **Hospice and palliative care experts** should be recruited to serve as members of pandemic planning teams, given the need to ensure that hospitals and NHs have access to expertise in advance care planning, symptom management, and end-of-life care, where available.
- **Local collaborations** can help states encourage NHs and hospitals to create their own transfer policies, which may require frequent adjustment based on local conditions.¹⁸ This can be done if local conditions warrant, based on hospital resources (eg, PPE, staffing, and bed occupancy), the care needs of the patients, and NH resources (eg, facility capacity for isolation and nonisolation care, PPE, and staffing). Consideration should be given to local collaborations that lead to dedicated COVID-19 facilities or units that have the expertise, PPE, and supplies to care safely for these patients.
- **Hospital discharge** also plays an important role in COVID-19 planning. As recommended by the CDC, the first and best option is to discharge to home in isolation with any needed home care.¹⁹ This will involve ensuring that enough home healthcare resources are available to patients who have remaining health needs. It also will involve the use of telemedicine for clinicians to monitor patients discharged to home. Given that this option will likely

only be feasible for a small number of patients, the federal government and states should build capacity to care for patients with COVID-19 after hospital discharge. This includes supporting NHs to readmit their own residents to isolation units or rooms, if available; identifying safe locations for those with wandering behaviors and highly complex care needs; and identifying housing for patients who are not stable enough for discharge to home but who still need support and close monitoring. States should explore "hospital-at-home" models of care, which can provide hospital-level care in the home environment and which should be paid for at parity with institutional hospital care to encourage further adoption.

- **Data** also are important to our COVID-19 response. Modeling of hotspots, supply of beds, and PPE must include NHs. This may require new integration of data sources into health information exchanges or other databases. Prediction models for post-acute care beds also will aid public health planning.

Issue 4: Workforce

There are several challenges and opportunities that will impact the availability and expertise of the workforce we need—both now and as we age.

Paid Leave

We recognize that Congress has taken steps to address access to paid family leave for all Americans. However, more must be done to ensure that all health professionals and direct care workers on the frontlines of addressing this crisis have access to paid family, medical, and sick leave. Ensuring access to paid leave is important for NH staff, including certified nursing assistants, dietary staff, and environmental support staff, as well as home care workers who are paid hourly, often lack paid sick leave, and commonly have marginal financial resources at baseline.

Screening

NHs should implement policies and procedures for screening staff aligned with guidance from the CDC and updated regularly to account for situational change. Infection among staff may be a source of exposure for post-acute patients and long-term residents in NHs. Quarantine rules must be carefully considered so as not to quarantine staff unnecessarily or for too long a period, which could decimate the NH workforce.

Training

All NH staff caring for residents who test positive for COVID-19 should be trained in infection control, the use of PPE, and recognition of COVID-19 symptoms. They also should receive any other training in accordance with federal, state, or local guidance. Resources—including rapidly developed online training tools—should be provided to support innovative training and mentoring for healthcare professionals and workers who are being quickly mobilized into new settings of care.

Staff Availability

State and local governments should include NHs in their emergency personnel distribution deployment considerations. This will ensure adequate and safe staffing ratios for all disciplines providing care to NH residents.

Issue 5: Payment and Tax Relief

Several considerations should factor into payment and tax relief, both to assist healthcare facilities and those who provide care within those facilities.

Payment

CMS should increase payment to NHs caring for residents with COVID-19, so that payment is commensurate with the added costs of enhancing staffing skills, the need for quarantine, and quantities of PPE and other supplies to care for this complex and vulnerable population appropriately. CMS should continue to solicit input from the clinician community and stakeholder organizations on what further modifications are needed in existing policies and regulations.

Tax Relief

Congress should ensure that tax relief is provided to those NHs that provide paid family leave to support nurses, therapists, and direct care workers caring for older adults and people with disabilities. While the recently passed Families First Coronavirus Response Act takes some important steps to support paid leave, it does not provide a way for most healthcare organizations to offset the costs of providing medical and family leave to employees. In addition to NHs and LTCFs, home care agencies, hospitals, assisted living communities, and clinician practices should have immediate access to federal grants, interest-free loans, or tax relief to help offset these costs.

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