What California Needs To Do To Protect Its Nursing Home Population

- The populations must be split so that COVID-19 positive patients are either in completely separate facilities, or in separate wings of the same building. They can not be commingled with COVID-19 negative patients/residents.
- The populations and facilities must be served by completely different staff members who do not go between the different facilities.
- Infrastructure and staffing efforts must effectively integrate knowledge and understanding of the industry that is vital to their successful implementation. This proposal does not add to the work already going on. It helps to insure that those efforts will not be wasted.
- COVID-19 positive facilities must be run under an incident command structure that allows for a management workflow that disseminates real time expert driven recommendations effectively.
- Clinical and operational aspects of this proposal are based on incident command principles, allowing the NHA to focus on their leadership abilities, rather than wasting energy and time trying to manage every department in the facility.

Why California Must Follow Massachusetts and Connecticut's Lead, Taking The Following Approach

We know that nursing homes have struggled with all types of infection prevention historically, just given the age and health of the population they serve and the close proximity between many of the residents.[1] Sending more COVID-19 positive patients to a facility that has a mix of infected and uninfected patients risks overrunning a facility that is already unprepared and risks increasing morbidity and mortality in that facility and in surrounding hospitals. The New England Journal of Medicine concluded "proactive steps by …facilities to identify and exclude potentially infected staff and visitors…are needed to prevent the introduction of Covid-19."[2] Drs. Grabowski and Joynt also have made the case in their recent article in JAMA, "Postacute Care Preparedness for COVID-19.[3] Hence, the concept of COVID-19 Positive Postacute Centers.

The idea of moving COVID-19 negative residents out of existing facilities in order to repurpose those facilities into COVID-19 positive facilities has significant drawbacks. First, there is literature on the impact of transfer trauma in nursing home residents.[4] Second, there is an unknown risk of introducing the virus during the transfer process. Third, there is no guarantee that the facility that they are moved to will be COVID-19 negative. There are also civil rights issues at play. These are the "homes" to these residents. Forcibly moving them may have a

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[1] https://khn.org/news/infection-lapses-rampant-in-nursing-homes-but-punishment-is-rare/

[2] https://www.nejm.org/doi/full/10.1056/NEJMoa2005412

[3] https://jamanetwork.com/journals/jama/fullarticle/2763818

[4] Dosa D, Hyer K, Thomas K, Swaminathan S, Feng Z, Brown L, Mor V. To evacuate or shelter in place: implications of universal hurricane evacuation policies on nursing home residents. Journal of the American Medical Directors Association. 2012 Feb 1;13(2):190-e1.

variety of untoward consequences. Transitions such as these are known to introduce an increased risk of errors and potential harm.[5][6]

Efforts are already underway to create alternative sites of care for COVID-19 positive patients that require a skilled nursing level of care. Plans to create the infrastructure and to provide the staffing are moving forward. This proposal helps to effectively integrate knowledge and understanding of the industry that is vital to the successful implementation of these efforts. *It does not add to the work already going on*, it just helps to insure that those efforts will not be wasted.

The COVID-19 pandemic is a medical emergency. This calls for the utilization of an incident command approach in COVID-19 positive facilities. Traditional nursing homes are managed top to bottom by a Nursing Home Administrator (NHA). This proposal allows the NHA to focus on their leadership abilities, rather than wasting energy and time trying to manage every department in such a facility. Management of each department will be supported at the state level by an incident command focused structure that provides real-time expert driven *direction* to the department heads of COVID-19 positive facilities.

As a simple and easily implementable start to this process, we continue to strongly urge the Governor to mandate that every nursing home in California give their Infection Preventionist (IP) full-time status. The California Association of Long Term Care (CALTCM) and Health Services Advisory Group (HSAG), the Quality Improvement Networks-Quality Improvement Organizations (QIN-QIO) for California, are prepared to provide the ongoing education and training of the IPs in nursing homes throughout the state as an actionable initial step towards implementing this proposal.

The clinical guidance for addressing COVID-19 in nursing homes and the nursing home population has been led by The Society for Post Acute and Long Term Care Medicine (AMDA). This guidance has been developed by experts on the front lines in real time and is now supported by expert panels created by The California Association of Long Term Care Medicine (CALTCM), and convened by Health Services Advisory Group (HSAG) that is prepared to disseminate information throughout the state. This expertise will be shared with Medical Directors and Directors of Nursing.

COVID-19 demands a well-reasoned, evidence-based approach to creating and supporting COVID-19 Positive Postacute Care Centers. This involves real-time dissemination of best practices through a new model developed specifically to stop the spread of this deadly pandemic and to limit the morbidity and mortality in the most vulnerable members of our population.

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[5] https://psnet.ahrq.gov/primer/long-term-care-and-patient-safety

[6] Davidson GH, Austin E, Thornblade L, Simpson L, Ong TD, Pan H, Flum DR. Improving transitions of care across the spectrum of healthcare delivery: A multidisciplinary approach to understanding variability in outcomes across hospitals and skilled nursing facilities. The American Journal of Surgery. 2017 May 1;213(5):910-4.

Details on How To Accomplish This Goal

The **ICOS** construct stands for **I**nfrastructure **C**linical, **O**perations and **S**taffing. It can quickly be put together virtually at the State level. It is described below.

- **ICOS: INFRASTRUCTURE, CLINICAL, OPERATIONS, STAFFING**
    - INFRASTRUCTURE
        - Immediately develop COVID-19 Centers that ONLY care for COVID-19 positive older adults
        - Coordinate the repurposing and creation of facilities needed to house older adults in any given community in the state and create a standard template for the facility working with skilled nursing facility physical plant experts
        - Work with FEMA, Army Corp of Engineers, Army Medical Corps and Regulatory bodies to coordinate the building, retrofitting, and supplying of new temporary housing for COVID-19 positive older adults
        - Adequate PPE and other supplies and equipment
        - Technology to allow for increased socialization while minimizing transmission of the virus
    - CLINICAL
        - Expert Multidisciplinary Teams (AMDA/CALTCM)
            - Experts interacting with clinicians in the field dealing with COVID-19 outbreaks and developing guidance in real-time for medical care
            - COVID19 Positive Care: develop expert supported clinical recommendations in real time for Directors of Nursing and Medical Directors
                - e.g., need for bluetooth-enabled pulse oximetry
        - Actionable recommendations are delivered back to the COVID19 Positive Postacute Care Centers
        - Utilize QIN-QIO to assist in dissemination of information
    - OPERATIONS
        - Mirrors the Organizational Chart of a nursing home (NH)
        - Models the communications process
            - In a pandemic, each department in a NH needs up to date actionable information that will not be effectively shared through the traditional chain of command structure and function
        - Operational Multidisciplinary Teams led by experts in a virtual Command Center
            - By Department, following NH Organizational Chart
                - Nursing home administrator, Director of nursing, infection preventionist, housekeeping, physical plant, dietary, therapy, etc.
            - Developing actionable recommendations daily back to COVID19 Positive Postacute Care Centers
            - Share information and integrate with individual facility incident command teams on a daily basis working in conjunction with the QIN-QIO

- STAFFING
  - A lot of people are out of work in the industries that have applicability to the nursing home workforce, e.g., housekeeping from hotels, dietary from restaurants, activities from leisure and entertainment.
  - Need to find and engage RNs and LVNs
  - Engage outside entities such as National Guard, Army Medical Corps
  - We need more Certified Nursing Assistants (CNAs)
    - CNAs are the backbone of nursing homes
    - Main requirement is to be a caring human being
    - On-the-job training programs are already available, just need to be expanded
  - Licensing regulations streamlined to allow on-the-job training
  - Utilize existing education and training approaches, waiving all fees, though may need to quickly adjust to more rapid training.