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Long-Term Care and COVID-19, What's Next?

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Since January 2020 when the coronavirus disease 2019 (COVID-19) was first detected in the United States, the impact of the disease in nursing homes and other long-term care residential facilities continue to unfold. Older adults in long-term care facilities are at greater risk of severe illness or death from COVID-19. It is of utmost importance to describe the needs of this vulnerable population during this unprecedented time and to identify specific guidelines for long-term care facilities to follow and to formulate prevention and mitigation strategies to contain COVID-19. In this article, positive cases of COVID-19 in skilled nursing facility (SNF) has been explored and the guidelines recommended by several state and federal health agencies have been discussed.

Positive Case of COVID-19 in SNF

The resident is an older adult male who is a crossdresser with several medical issues including asthma and hypertension. In addition, he experiences repercussions from a previous stroke resulting in left-sided weakness. He has been in the SNF for 6 years. The resident did not want to share a room with other male patients, so he shared it with a female. His medications include antihypertensive and pain management prescriptions. He has been independent most of the time in the SNF as he was able to feed himself and do some of his personal hygiene. He requires minimal assistance on transferring from the bed to wheelchair and vice versa but needs extensive assistance in dressing and taking a shower. The resident has been sociable and roamed around the facility in a wheelchair.

The resident has been coughing a lot for a week, but he rationalized that his cough was due to having asthma. On April 30, 2020, the resident complained of a sore throat and slight chest pain and was sent to the hospital at 1430 for COVID-19 testing. At 2030, the COVID-19 test came back with positive results. He remained fully oriented, had no medical contraptions, and was continent of bowel and bladder.

Issues in this SNF include inadequate isolation rooms to keep COVID-19 contained. The resident did not return to the SNF as the facility could not provide care for COVID-19 residents. The area of the SNF where the resident had resided was "locked down." Residents in that area were not allowed to go outside of their rooms for any reason and were fed inside their rooms. In addition, no visitors were allowed into the facility. Yet the SNF nursing staff were assigned on a rotation basis to care for the residents rather than permanently assigned a nurse to a specific resident

As of May 20, 2020, the facility had six cases of COVID-19. The first case was the receptionist, the second case was the resident in the above case report, and a third case was a certified nursing assistant. Three other residents tested positive for COVID-19 and were transferred to the hospital. When staff come to work at the facility, their temperatures are being measured in the entrance hall and documented. If staff show any COVID-19 symptoms such as a cough and fever, they are not allowed to come to work. Staff should always wear personal protective equipment (PPE) which includes face shield, mask, gloves, and a gown. Thus far, they have enough supply PPE provided by the facility to care for the residents.

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Discussion

As COVID-19 continues to spread, the pandemic has presented several challenges to the 15 000 nursing homes and SNF in the United States (1). For one, it is difficult to contain the virus once it seeps inside the confines of a long tem care facility (LTCF). The coronavirus is highly contagious in the community and even more so in health care institutions. LTCF residents share the same living environment and caregivers which is compounded with many visitors from the community entering the facility enabling the spread of pathogens. Thus, once COVID-19 enters the LTCF, it is hard to manage its spread due to the shortage of manpower and resources for infection control in LTCF (2).

The possibility of asymptomatic carriers complicates the issue of containment of the coronavirus, as many LTCF have reported residents who have no signs and symptoms of COVID-19 yet test positive for the disease (2). It is not known with certainty whether asymptomatic carriers can infect others. The reliability of the actual tests is also in question as to their dependability to produce accurate results as there are many different tests on the market. Yet the COVID-19 test is needed to determine who has the disease in order to undertake specific actions for isolation and do contact tracing and testing on those who may have been exposed. Not only has COVID-19 testing been dubious in the LTCF setting, but there has been an inadequate supply of PPE. Staff and residents in LTCF have to be provided with PPE and required to wear all the time. Ideally, PPE has to be changed daily but has been encouraged to reuse due to lack of supply.

In the United States, over 4 million people reside in nursing homes and skilled nursing facilities (3). The rate of infection in long-term care facilities has limited data yet it is estimated that 1 to 3 million residents succumb to an infection each year while residing in a long-term care facility (3). Long-term care residents are prone to infections as many have comorbidities including chronic diseases coupled with their frailty. This, it is not surprising that respiratory infectious diseases such as influenza, pneumonia, and norovirus caused by different pathogens have been serious challenges for individuals residing in long-term care facilities (4). Infections are a chief source of hospitalizations and death as over 380 000 people in LTCF die each year due to infections from many sources (3). LTCF residents are particularly vulnerable to COVID-19 and succumbing to respiratory complications often culminating in respiratory failure and death caused by the novel coronavirus (5).

Care workers in LTCF setting face physical, mental, and psychosocial demanding working conditions. Severe time pressures and work overload have experienced by many workers, especially during the pandemic. Due to demanding care work, LTCF suffers from high levels of absenteeism and high turnover rates due to poor working conditions. In consequence, there is not an adequate workforce remain in the long-term care sector which compromises the safety of the older adult patients.

Recommendations

Several state and federal agencies have made concerted steps to formulate prevention and mitigation strategies to contain COVID-19 within LTCF. Centers for Medicare & Medicaid Services (CMS) has set forth several policy changes guidelines include that LTCF should limit if not ban outside visitors and cancel group activities and communal dining. Furthermore, routine inspections of the LTCF by CMS have been suspended to focus on infection control. Centers for Medicare & Medicaid Services has also made modifications for permitting reimbursement of telehealth visits. Transfer rules have been relaxed allowing Medicare to cover admissions to the nursing home before the 3-day minimum hospital stay allowing COVID-19 residents to either be grouped or better separated. Increased reimbursement for testing has also been endorsed by CMS (6).

Recently, the Center for Disease Control (CDC) also put out guidelines for long-term care facilities to help contain the disease within the facility and to keep staff and residents safe from contracting the virus. The CDC has specific resources related to COVID-19 for long-term care facilities including a preparedness checklist and guidance on infection prevention and control (7).

The American Geriatrics Society (AGS) has made several recommendations such as the enactment of the Defense Production Act to increase the production of PPE, testing kits, and supplies for symptom management and end-of-life care. The coordination of the supply chain with state and federal governments needs to be centralized, and AGS proposed that the US Department of Defense undertake such a task. Other recommendations by AGS include the safe transfer of COVID-19 patients including not discharging positive COVID-19 patients from the hospital to a traditional nursing home. In addition, before transferring a COVID-19 resident from the LTCF to the hospital setting, patient-centered goals need to be well understood as pertains to individual preferences for end-of-life care and if the LTCF can manage such goals. American Geriatrics Society has also made several recommendations pertaining to Public Health planning to advocate for geriatric health professionals, nursing home leadership teams, and hospice and palliative care experts to be part of the pandemic response and planning teams. Last, recommendations were made as pertains to the workforce including better access to paid leave, enhanced screening for COVID-19, and increased training in infection control for health care professionals and staff in LTCF (2).

In conclusion, as the United States remains in the midst of a pandemic in which older adult residents in LTCF are most vulnerable to experiencing detrimental effects from the virus, guidelines must be established and followed. The CMS, CDC, and AGS have put forth ample recommendations to assist LTCF in making informed decisions to minimize the threat of the virus. LTCF is faced with an environmental restructuring and instituting policies to enact social distancing and infection control. Since we've only

known about coronavirus in such a short period of time, there are so many uncertainties about what will happen next.

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