The Pandemic Creates Urgency Around Designing Health System Support Structures for Nursing Homes

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Abstract

This editorial comments on:

Montoya, A., Jenq, G., Mills, J. P., Beal, J., Chun, E. D., Newton, D., Gibson, K., Mantey, J., Hurst, K., Jones, K., & Mody, L. (2021). Partnering with Local Hospitals and Public Health to Manage COVID-19 Outbreaks in Nursing Homes. *Journal of the American Geriatrics Society*, *69*(1), 30–36. https://doi.org/10.1111/jgs.16869

Providers on the front lines caring for residents in nursing homes are bearing witness to the misery suffered by residents and staff during this pandemic. It is critical to distill lessons learned where we can to disseminate best practices to prevent further morbidity and mortality in this setting. The authors are to be commended for their description of an outbreak investigation in three Michigan facilities.[1] They present a clear and helpful description of outbreaks that were well contained. Their experience highlights both the importance of testing and of the ability of a health system to support care and services in nursing homes.

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In response to an outbreak that was discovered in the course of symptom-triggered testing in these facilities, facility-wide testing was performed to determine the in-house prevalence of COVID-19. Additional cases were identified among asymptomatic residents, who were then divided into cohorts in COVID-19-dedicated units. The facility floor plans presented with this article map these positive cases. In particular, in two of the three facilities, the asymptomatic positive residents were not obvious contacts, for example, they were not roommates or adjacent to known positive residents. On August 26, 2020, the Centers for Medicare and Medicaid Services issued guidance for testing of residents and staff in nursing facilities.[2] This includes (1) symptom-triggered testing for any resident or staff; (2) testing all staff and residents every 3–7 days in an outbreak (defined as any newly positive staff or resident) until no new positives are identified for 14 days; and (3) routine surveillance testing for staff. Routine staff testing frequency is dictated by the positivity level in the county of the nursing home and ranges from twice weekly to monthly. Although nursing homes across the country are stretched to identify resources to test, track, and report this information as mandated, clearly, regular testing is key to identifying and mitigating outbreaks.

The authors discuss the importance of leveraging preexisting relationships with a health system to coordinate a response and gain additional expertise. They encourage nursing homes to seek out these relationships. Before the pandemic, they describe longstanding quarterly meetings between facility clinical and administrative leaders and hospital administrators to discuss quality metrics, clinical initiatives, and communication issues. Furthermore, the medical leadership in these facilities is employed by the health system, strengthening the relationship. Where similar collaborative relationships or learning networks existed, there was a foundation to mount a coordinated response to support residents and staff in nursing homes during a time of unprecedented challenges. These examples demonstrate the power of investing in stakeholder relationships and having bidirectional

information channels. Other facility clinical and administrative leaders, however, have had difficulty in finding support from regional health systems.

Now that the initial surge of COVID-19 infections has been navigated in most regions, health systems should learn from this and similar experiences and be receptive to nursing homes asking for support and, at the same time, proactively reaching out to area facilities.[3, 4] Nursing home staff and leaders are well experienced in caring for complex older residents with functional and cognitive support needs. Health system support, in the form of infectious disease and palliative care expertise, personal protective equipment (PPE), access to testing, and clear communication protocols during transitions to and from nursing homes, will be welcomed.

Another factor this pandemic has shed light on is the importance of integrating nursing home data sources with other healthcare data. From a public health standpoint, aggregating total numbers of hospitalized patients with COVID-19, or any infectious disease, across a state is helpful but limited if we cannot identify key pieces of information about these patients. Clearly, cases originating from a congregate setting, such as a nursing facility, should be considered critical data from a public health standpoint. A majority of nursing homes utilize electronic health records, and all Medicare and Medicaid certified facilities collect standardized data on all nursing home residents through Minimum Data Set assessments. It is possible to link these data sources with health information exchange networks, if it is considered a priority. In addition to the obvious case of COVID-19, such integration would support the implementation of automated data at the time of any transfer and help chip away at the many continued communication problems across settings.

Examples of best practices to mitigate the impact of COVID-19 on nursing home residents, as described in this article, should inspire healthcare stakeholders to create meaningful, mutually beneficial

relationships across settings to improve patient care. No nursing home administrator, medical provider, or front-line nursing assistant should feel they are fighting this alone.

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Conflict of Interest

Kathleen T. Unroe is CEO and Founder of Probari, Inc., a healthcare start-up designed to improve care in nursing homes.

Author Contributions

Kathleen T. Unroe is the sole author.

Sponsor's Role

None declared.

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