Conference Call Convened at 9:00 a.m. Eastern Daylight Time

✓ **Present**

✓ Jonathan Balllard	✓ Paul Drager	✓ Tom Sherman
✓ Kathy Bizarro-Thunberg	✓ Anne Edwards	✓ Lori Shibinette
✓ Charlie Burney	✓ Luanne Rogers	✓ Stephen Surgenor
✓ Polly Campion	✓ David Ross	✓ Elizabeth Talbot
✓ James Culhane	✓ Melissa St. Cyr	✓ Carole Totzkay
✓ Jeff Dickenson	✓ Deborah Scheetz	✓ Tom Wold

Number of Persons with COVID-19[1]	2,740
Recovered	1,110 (41%)
Deaths Attributed to COVID-19	111 (4%)
Total Current COVID-19 Cases	1,519
Persons Who Have Been Hospitalized for COVID-19	307 (11%)
Current Hospitalizations [2]	113
Persons Tested Negative at Selected Laboratories [3]	26,066
Persons with Specimens Submitted to NH PHL	11,174
Persons with Test Pending at NH PHL [4]	345
Persons Being Monitored in NH (approximate point in time)	2,900

[1] Includes specimens presumptive-positive at any laboratory and those confirmed by CDC confirmatory testing.
[2] Number of patients currently hospitalized with COVID-19 as reported by hospitals.
[3] Includes specimens tested at the NH Public Health Laboratories (PHL), LabCorp, Quest, Dartmouth-Hitchcock Medical Center, and those sent to CDC prior to NH PHL testing capacity.
[4] Includes specimens received and awaiting testing at NH PHL. Does not include tests pending at commercial laboratories.

Conference Call Agenda

1. What does CSC for LTC look like?
2. What would are the triggers for CSC in LTC facilities?
3. What do LTC facilities need to avoid implementing CSC?
4. What are some solutions for preventing

Ballard: What is your perspective of the situation in LTC facilities as they respond to COVID-19?

Ross: There are four key essential services that must function in a LTC facility in order to deliver optimal care. An inability in one or all four would result in a crisis.

1. Dietary
2. Housekeeping
3. Laundry
4. nursing/medical care)

Rogers: I concur with David's assessment.

Ballard: critical staffing?

Ross: Smaller facilities could be in crisis if key staff are out. Nursing services are more impactful especially with Licensed Nursing Assistance (LNA). However, many facilities function, even before COVID-19, at less than optimal operational staff. Most function at the contingency level of staffing. We are hopeful with the possibility of adding temporary caregivers. This would reduce training time. LNAs require 100 hour training.

Long-term care nursing is a specialized skilled set. These nurses carry 20+ cases per shift. It is difficult to transition ambulatory care nursing to LTC facility nursing. Each facility would need to identify the number of staff that are not available to determine crisis level.

L.Rogers: For facilities without COVID, we only use an agency worker that is in our and not share with another facility that has COVID. Compromise if use agencies that float among facilities that have COVID. Staff are afraid and won't come in and Staff that are sick and can't come in.

K.Bizzaro: Do we know how many LTC facilities in the state that are close to or at Crisis? Could we standardize a risk assessment for LTC use like we use in hospitals?

E. Talbot: We need to have this. The facilities many not be able to keep up with equipment and other resources. It would be helpful to have this information.

Ross: We are piloting Juvare with the GSHCC. We would have to provide guidance on LTC CSC for the facilities.

Bizzaro; We had a small group of clinicians that developed the hospital-based definitions. Helps us to understand the shift within hospitals.

Possible Solution: We could establish a small group of specialized LTC clinicians to start creating a dashboard for LTC facilities.

Sherman: We have a volunteer network, Senior Support, that Polly is involved in. We have 65 facilities involved with a pilot for capturing data. Also working with NH DOS Asst. Commissioner Perry Plummer on adding some facilities into Juvare.

Action Item: Find out status of pilot LTC listing in Juvare.

Ballard: What would be altered/alternative standards of care (ASC)? We can come back to the solutions. Is there frequency differences with care delivery?

Ross: ASC suggestion would be the makeup of care providers.

1. Currently use Licensed Nurses. We may need to pair up licensed and unlicensed nurses when caring for a patient.
2. Keep residents in bed vs out of bed.
3. Reduce need to showers and baths.

Rogers: Maybe do two shifts a day instead of three. LTC has always struggled with care delivery due to inadequate staffing. So we have found ways to do more with less.

Dickinson: Minimize unintended consequence of paying staff.

Ross: We may want to consider those currently unemployed.

Rogers: Patient Care Assistance is an online course that can be used temporarily.

Sherman: In-hospital setting reuse of PPE. The nursing homes have been creative with gown shortages and cloth masks. These are examples of ASC.

Rogers: ASC does expose our staff to illness however.

Ross: All buildings are on extended use of PPE. A crisis would be using trash bags as a covering.

Ballard: Other thoughts.

Campion: Reliance on family members to be caregivers. This would be complicated and present additional challenges. However, in a real crisis it may be needed.

Talbot: This action could bring in more disease, but appreciate the idea.

Rogers: We have had some families that have volunteered.

Ballarad: non-essential medications like vitamins, could this be limited?

Ross: This is a good idea.

Rogers: This is already part of our plan. Limit the number of med paths of delivery. Weekly weights could be adjusted.

Ballard: Transfer of patients out of LTC?

Ross: Transfers happen under at least two possible scenarios:

1. When a facility cannot meet the clinical acuity of a patient.
2. The facility needs to be evacuated.

Rogers: Another is when we discuss the patient's advanced directives with the patient and family member(s) regarding all aspects of their care. There comes a time when family and patient want more aggressive care, if so, then we need to transfer the patient.

Speaker ?: There are patients with a DNR and/or do not transfer orders. The patients pose challenges to care.

Phone disconnected by accident.

Talbot: Missed comment.

Ross: We must use a symptom log for respiratory treatment.

Rogers: Access has been limited for provision of respiratory treatment.

Ballard: Let's look at solutions. New guidance being released (Dr. Ballard, I didn't catch what this is.)

Ross: Available of rapid testing at the entrance of our building. We screen out 5-10 staff daily. It can take 7 days to get staff test results back.

Ballard: If we had turn around on testing to 1-2 days would that make a difference?

Ross: That would be helpful.

Rogers: It would be critical for our patients as well. We need faster turn-around time on tests.

Wold: The CDC came out this week on testing and return to work. It is changing our 10 + 3 day recovery days. There are a number of patients that test positive up to 30 days. 10 day return with resolutions of symptoms.

Talbot: Thank you for promoting this. I do think it will help with PPE and work care force.

Ballard: Clarifying questions.

Talbot: Not use the test-based tragedy. Use 10 days of symptom onset and 3 days of no symptoms.

Ross: We followed 7-day/72 hour. S0 the change to 10 and 3 extends this but it's ok. Out of work until test results or 10-day/3-day. When we have 10 employees out of the facility, it will place the facility in crisis. To Luanne's point, the use of PPE in the 10-day period can be challenging, cumbersome, and impactful to facilities.

Talbot: Getting employees tested has always been a priority. Appreciate the ethical perspective from David.

Ballard: I have seen the Massachusetts LTC model. Would implementing the model or parts of it in NH be beneficial?

Ross: In crisis, it can be lifted to assign employees to work on a COVID positive unit. My understanding of MA's model, is that a rapid response team goes into a facility to help with

patient care but also evaluates the facility and its operations to help with transitioning from crisis to usual care. The rapid response team is in the facility for 4 to 5 days.

Rogers: The goal would be to prevent spread once it starts.

Ballard: CMS is hosting a call on Friday to link furloughed workers with LTC facilities; some other models too. Do you see this as more helpful than using staffing agencies?

Ross: This would be invaluable. Add more folks to the pool.

Rogers: Even our agencies are beginning to struggle with staffing.

Ballard: Anymore solutions on staffing?

Sherman: We have been looking at the hospitality industry to transition employees to help LTC facilities. Working with NH DOS HSEM and the NH Department of Labor. We can pursue this further.

Campion: We need to work with the NH Board of Nursing and the Board of Licensure to expedite licensing of nursing students those students applying for LNA. Have any of you seen these students coming to your facility?

Ross: No. We have seen a delay of LNAs. There is an inability to process applications at the Board.

Rogers: I have two LNAs that need their licenses renewed.

Campion: That's helpful information. Thank you.

Ross: It would be helpful to get the expedited LNAs.

Campion: There may be others on the phone to help ease the Office of Professional Licensure and Certification (OPLC) delay.

Ross: Maybe move to a competency-based model and have the LTC facilities issue certificates.

Rogers: Catholic Charities has issued a program. We have applied to the OPLC for approval of the program certification.

Ballarad: Ramp up testing for people across the State. Any ideas?

Talbot: A lot of pressure of reopening would lift the social-emotional burden. We are increasing public messaging to get tested.

Rogers: The DHHS Commissioner announced that there will be surveillance testing for LTC. I tested all my staff Friday and the patients were tested yesterday. Mobile units are going out every 7-10 days to randomly test staff; will get supplies to rapid test patients.

Talbot: Yesterday was a big day for public health announcements. I continue to think that positive results can be acted and updating our case response. Cohorting is a challenge in facilities.

Ross: Most providers would approve an off-loading facility. Need guidance for facilities for 5 minutes, 5 hours, 5 days when a positive case is identified.

Burney: What has changed regarding admission policies? Off-loading? Temporary transfer to a COVID-19 unit hospital?

Talbot: Do we have to quarantine people if they came from a facility? What if a single case? Can they transfer that one patient? I don't think we have been explicit in our State guidance. Willing to take this on.

Surgenor: I am looking for more comments on moving patients between LTC, acute care facilities and back.

Ross: We have isolated new admission patients for 14 days.

Rogers: We are a 50-bed facility and use 6 beds for isolation.

Ballard: That's all I have. Let's open the line for public input. No public comments.

Sherman: Rather than further rejecting volunteers/family members assistance, if we could adequately test them wouldn't that put them back into supporting the facility?

Talbot: The current diagnostics do not support the model until we have antibody testing.

Sherman: If I were triaging optimal staffing solutions, I would support the use of family members. I'm watching Massachusetts use of National Guard.

Dickinson: I endorse Dr. Sherman's comment. We need to draw on furlough staff. Is the situation for volunteers any different than with staff?

Talbot: Yes. I think your right. One issue we haven't touched on is palliative care. The COVID palliative care guidelines are helpful. I'm wondering if we should promote them. So, I propose this as a new idea. Anyone with experience with this? Hearing nothing, I think we will take this under consideration.

Rogers: We have our advanced directives (AD) for each patient in place. The AD touches on the palliative care approaches.

Talbot: Are any of the patient's ADs COVID-19 specific?

Rogers: No.

Ross: I think our medical director would appreciate AD's related to COVID-19.

Drager: Nebraska is taking its POLST form and modifying it for COVID-19 patients. Palliative care should be on the forefront for any patient for any of a number of reasons. We need to tread carefully. We don't want to water down what an AD actually is.

Culhane: We are talking LTC as a single entity when it really encompasses a diversity of community living environments. Other facilities such as skilled and assisted living communities, subscribe to palliative care models as well.

Ross: We need each type of facility to identify what constitutes a crisis level for them.

Ballard: Any members of State government wish to speak.

Edwards: I have sent an email to the OPLC to see if we can break any log jams.

Ballard: Any members of the public wishing to speak? Hearing none. We will review the notes and present our findings to the full SDMAC. The DHHS senior leadership will take these ideas of staffing and resource support under consideration. Thank you for your work. We will end the call. The state Triage will meet on Friday, May, 15 at 9am. We will reconvene the SDMAC the following week. I will send the subcommittees a request for leaders. We will involve ethics in all of our groups.

Call ended at 10:40 a.m.

Possible resources to include with these notes:

1. COVID-19 Long-Term Care Facilities and Services. This guidance is for all long-term care facilities, assisted living facilities, and facilities serving people with developmental disabilities in Wisconsin caring for patients who are elderly and/or have chronic medical conditions that place them at higher risk of developing severe complications from COVID-19. By helping facilities improve their infection prevention and control practices in order to prevent the transmission of COVID-19, together we can flatten the curve.

   https://www.dhs.wisconsin.gov/covid-19/ltc.htm

   https://www.dhs.wisconsin.gov/covid-19/nurse-aide.htm

2. The Society for Post-Acute and Long-Term Care Medicine. As we all work to provide the best care we can to our patients and residents and prevent the spread of COVID-19, we have developed some specific guidance on the care of residents with dementia.

   https://paltc.org/sites/default/files/Caring%20for%20Residents%20With%20Dementia.pdf

3. Washington State Department of Health. Nursing Home Infection Prevention Assessment Tool for COVID-19. The following infection prevention and control assessment tool should be used to assist nursing homes with preparing to care for residents with COVID-19. Elements should be assessed through a combination of interviews with staff and direct observation of practices in the facility.

   https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/NursingHomeAssessmentTool.pdf

4. State of Massachusetts Long Term Care Facility Staffing Team.

   https://covid19ltc.umassmed.edu/Home/FAQ