
IMPACT OF COVID-19 ON LONG-TERM CARE IN INDIANA

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STATE LONG-TERM CARE SETTING

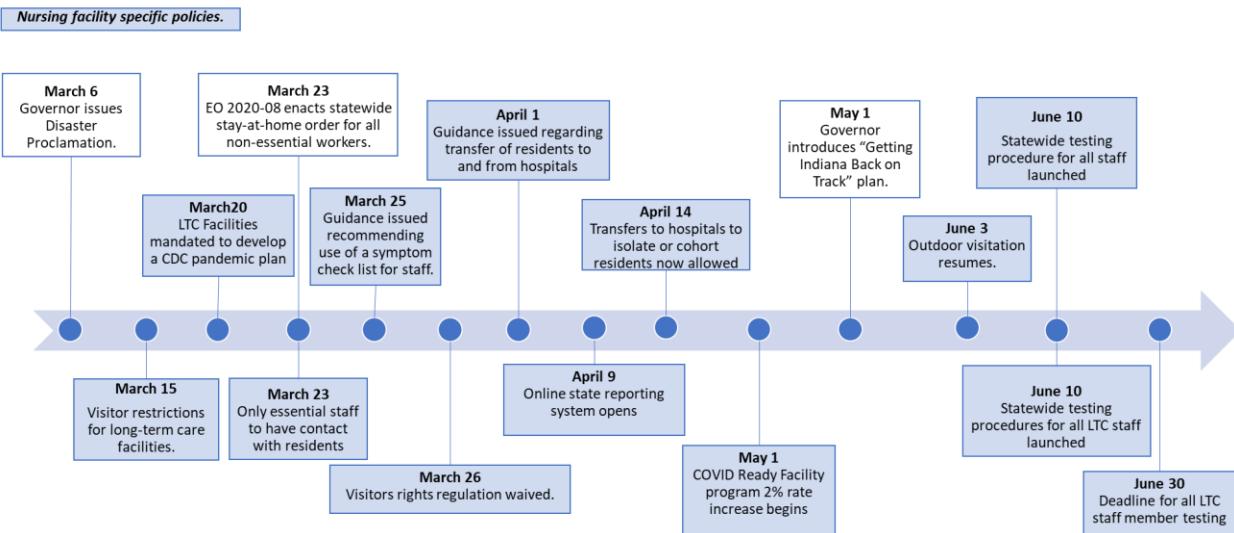
According to 2017 data from the Kaiser Family Foundation, Indiana had 552 certified nursing facilities caring for 38,682 residents. Indiana nursing homes tend to be large, ranking 14th nationally with an average bed size of 114 per facility. Licensed nurse hours per resident day was 1.7 hours, ranking Indiana at 13th highest in the country. Rank for total staffing hours per resident day is far lower at 37, with 3.9 average total staff hours per resident day. Recent data reported in the Indianapolis Star (3/11/20) places Indiana at 48th nationally in regards to overall staffing, however it is noted that no external source is provided for that ranking apart from “an Indianapolis Star analysis of federal data”. Indiana is below the United States (US) average of 70% in for-profit ownership, and ranks 47th with 39% for-profit facilities. However, according to 2017 data Indiana ranks third in government owned facilities at 36%, considerably higher than the US average of 7% government ownership. More recent media reports in the Indianapolis Star (3/11/20) and the South Bend Tribune (3/15/20) have indicated that 93% of Indiana nursing homes are owned by county governments, a result of a state-wide strategy to extract federal Medicaid dollars, some of which have been used to support county hospital services through a rule that increases Medicaid payments for county owned facilities. [Changes to federal requirements regarding ownership are changing](#), which may impact the high percentage of government owned facilities in Indiana in the future. The primary payment source for Indiana nursing home care is Medicaid, which pays for 64% of care, above the US average of 62%. Twenty-two percent of Indiana nursing home care is privately paid, below the US average of 25%. Only 3% of Indiana nursing homes are hospital based (US average 5%), and occupancy rate is 73% (ranked 40th lowest state).

STATE COVID-19 OUTBREAK AND POPULATION LEVEL MEASURES

Indiana had 43,655 confirmed positive cases as of June 26, 2020. Indiana's rate of infection was 6,773 cases per million population, similar to yet below the US rate of 7,864.8 cases per million persons. COVID-19 deaths per million population were 392, slightly higher than the US rate of 384 per million population. COVID-19 fatality rate in Indiana was 5.8%, higher than the fatality rate among reported cases in the US as a whole (4.9%). Nationally, Indiana ranked 22nd among states in cases per million population, and 13th in deaths per million population. Importantly, cases of COVID-19 were not evenly geographically distributed within Indiana. Almost 17,000 of the confirmed cases and almost half of the 2,448 COVID-19 deaths have occurred in the Indianapolis metropolitan area. There was also a noted ethnic disparity in cases: African Americans comprised 9.8% [of Indiana's population](#) and [12.3% of cases](#); Hispanic persons comprised 7.1% of Indiana's population and 11.4% of total cases.

Nursing home residents represented 12% of total COVID-19 cases, yet accounted for 44% of total COVID-19 deaths. As of June 25, 2020, 5,147 nursing home residents tested positive for COVID-19 and 1,140 residents had died from the virus. Approximately half of facilities in Indiana had at least 1 positive case (268). It is challenging to understand the timeline and the geographic distribution of COVID-19 spread in Indiana nursing homes state reporting requirements that were quite loose at the beginning of the pandemic. Facilities were not required by the state to publicly report cases or deaths, a situation that has been criticized by advocacy organizations such as [AARP](#). Challenges to accessing accurate information about the spread of COVID-19 in Indiana nursing homes have been documented by a number of media sources in the state ([www.wthr.com](#), 6/9/20; [www.wfyi.org](#), 6/10/20; [www.tribstar.com](#), 5/21/20; others). Data was released outlining cases by specific nursing homes from [federal authorities](#) as of June 4, 2020, yet local authorities and media sources cited inconsistencies between that data and what had been locally reported ([www.wthr.com](#), 6/4/20; [www.indystar.com](#), 6/4/20). Figure 1 below illustrates the initial response to COVID-19 in Indiana.

Figure 1. Initial Response to COVID-19 in Indiana



RISK MITIGATION STRATEGIES

Testing of residents and staff: A symptom driven testing approach. [As part of a COVID-19 toolkit distributed by the Indiana State Department of Health \(ISDH\) on March 25, 2020](#), facilities were instructed to use the Centers for Disease Control (CDC) developed Respiratory Surveillance Line List to complete a Respiratory Surveillance Outbreak Summary. These documents provided a check-list of symptoms and were designed to monitor respiratory symptoms among both residents and staff. Access to testing was triggered by facility self-report of symptoms. The ISDH reported having capacity to test any symptomatic resident or staff member, and access to testing occurred through reporting of symptoms in the outbreak summary. A recommended/ required frequency of symptom surveillance documentation was not noted in the tool kit instructions, and information regarding timing of symptoms or testing among staff and residents was not publicly reported. In a televised press conference on April 8, 2020 the Indiana Health Commissioner noted that 600 tests had been conducted in nursing homes, with 191 positive cases and 31 deaths, representing both staff and residents.

Results of tests were expected within 5 to 7 days of testing. Turnaround time for tests varied by lab. Initially, facilities would wait up to a week for results, yet as lab capacity in the state improved, so did turnaround times which shortened to 24-48 hours. However, as other health care settings reopened, such as elective surgeries, wait times were again affected given increased volume of tests. There was not a centralized test processing facility; nursing facilities in Indiana use a variety of labs. Some had arrangements with health system labs, some with private labs in or out of state. Initially there was more reliance on ISDH testing, however, this has shifted as private lab capacity improved.

Moving to an all staff testing approach

A symptom driven testing approach remained in place until June 8, 2020, and included contact tracing when infected residents or staff were identified (e.g., testing entire wing of residents and staff). On June 8th the ISDH issued an urgent memo outlining a mandatory COVID-19 testing procedure for all nursing home staff, approximately 58,000 people. Following multiple conversations with industry stakeholders and study of Federal guidance, ISDH launched a statewide all-staff testing initiative on June 10th. Nursing homes could opt to have test kits delivered between June 10-22 on a date scheduled by the state and administer the tests themselves; in which case ISDH returned to collect the samples for processing within twenty-four hours of receiving the testing kits in order to maintain the integrity of the samples. Or, alternatively, facilities could opt to have ISDH conduct onsite testing between June 23-28. The vast majority of facilities opted to receive kits and test on-site. Employees were directly notified of results and facilities were notified of all positive results by phone call, as well as having access to a State

web-based portal to obtain a complete list of results for their staff. In addition, facilities were required report any staff who refused testing. Staff who previously tested positive for COVID-19 were not re-tested. The ISDH-provided rationale for this one-time all-staff testing strategy was to provide a point in time view of asymptomatic COVID-19 positive nursing facility staff.

All staff members must have been tested by June 30 unless they had been otherwise tested in June or had previously tested positive for COVID-19. Staff members could also report to an external testing site operated [by the state partnership with company named OptumServe](#) for a free test if uninsured.

Nursing facilities were encouraged to develop a protocol for staff to report to the facility that their test has been completed and if the result is positive. ISDH planned to use the results of this all staff survey, combined with other data sources including a recent state-wide point prevalence study, to create guidance for ongoing staff testing protocols.

The Indiana State Department of Health (ISDH) established a centralized contact tracing system for COVID-19 case investigation in Indiana. When COVID-19 cases were confirmed, a contact tracer called the positive individual to determine with whom they have had recent contact. If it was determined that an individual is a resident or staff member at a long-term care facility, the local health department followed up and monitored for any potential outbreak in that facility (www.ihca.org). Asymptomatic staff with pending tests could continue to work with a mask requirement. Asymptomatic staff who tested positive for COVID-19 quarantined at home. However, in a staff shortage they were allowed to work in a dedicated COVID-19 unit.

Use of Personal Protective Equipment (PPE): evolving guidance. The ISDH advised facilities on March 18th, 2020 to use fit tested N95 masks *only* for essential staff performing procedures with COVID-19 positive residents that have high potential to generate respiratory aerosols, such as nebulizer treatments, and not for lower risk procedures or non-essential staff members. Facility staff were advised to wear surgical masks with eye protection, gown and gloves when treating COVID-19 positive residents. All PPE was advised to be prioritized to highest risk staff and procedures. Staff were advised to remove uniforms and don clean street clothes prior to leaving work for the day. On March 20th guidance was issued that all staff wear a standard facemask during their work shift, from beginning to end. On March 23, 2020, in a letter to facility directors, the Indiana Health Commissioner recommended that in addition to all staff wearing masks, only essential direct care staff should have contact with any resident or be in any resident's room. To preserve masks, the Commissioner advised that staff wear one mask throughout their shift.

Hospitals participated in a state system, EMResources, to log their supplies of PPE and other equipment. Nursing facilities had not traditionally participated in this system and were brought on-line with it during the pandemic. Additionally, in May through mid-June federally accessed PPE was delivered to 530 Indiana nursing homes, with priority given to infection 'hot spots'. A spread sheet with "PPE push" numbers by facility is available at www.ihca.org, the website of a long term care provider association in Indiana. A media report on April 13, 2020 (www.wishtv.com) indicated that nursing homes were not given priority access to the state supply of personal protective equipment (PPE), prioritizing hospitals and leaving some nursing homes without necessary PPE. The accounts of PPE shortage in the media were anecdotal until federal facility-level data became available in June through Centers for Medicaid & Medicare, at which time only 45 of all Indiana nursing homes report not having a week supply of masks available.

Use of "strike teams"

State "strike teams" were developed from the regulatory surveyor work force (who per CMS guidance limited their regulatory surveys to immediate jeopardy situations) to perform PPE training and targeted test collection, with priority given to facilities with COVID-19 positive residents. These visits were not

regulatory in nature. On March 20, 2020 facilities were notified of the need to adapt the Centers for Disease Control (CDC) checklist to meet the specific needs of their facility, and maintain this tool to assess, plan and implement as the pandemic continues. On March 25, 2020, the ISDH compiled and distributed a COVID-19 toolkit (link provided above), including current guidance, recommendations, preparedness checklists, infection control guidelines, and other documents.

In addition to strike teams, the Probari RN Team was an available resource to assist them in managing training and staff support. Throughout April, May and June, the Probari team (an Indianapolis based healthcare start-up) supported ISDH staff by communicating best practice guidance and test results to nursing facilities and assisted living facilities. Probari has also supported with the statewide testing program for staff in June.

Movement of staff and residents within and between facilities: a cohorting approach. On March 18th, 2020, the (ISDH) issued guidance that residents with confirmed COVID-19 infection should be placed in contact/ droplet precautions with use of proper personal protective equipment (PPE), including gown, gloves, mask, face shield/ eye protection by contacting personnel; proper donning and doffing of PPE by staff. Additionally, reduction of non-essential staff who come in contact with the resident was recommended. Non-essential staff were defined as any staff member that does not perform medical care. Guidance from ISDH to facilities read, “ONLY ESSENTIAL staff should go into the room of a confirmed or presumed COVID-19 patient.”

Reduction of staff movement between patients with and without COVID-19 infection was recommended using the following approaches: quarantining a cohort of staff and residents with COVID-19 within one portion of the facility, and not sharing equipment between the infected portion of the building and the remainder of residents. Staff who had contact with an infected or presumed infected resident were also advised to work at only one facility, particularly pertinent for contract staff who may travel between facilities daily. Cohorting, or the moving of positive residents to reside with other positive residents, was advised to be done by building if possible, then floor, or if necessary wing. Other mitigation guidance on March 18th, 2020 included single rooms and private bathrooms for infected residents, and isolation of residents who had contact with an infected or presumed infected person for 14 days. Guidance to medical directors on March 18th, 2020 were to refrain from ordering routine labs and x-rays and consider the discontinuation of respiratory treatments that emit aerosols.

A blanket waiver was issued was issued on March 26, 2020 allowing facilities to care for COVID-19 positive residents in rooms otherwise unlicensed for care, or in a facility otherwise unlicensed for skilled care in order to meet isolation needs as long as the plan for safe care was communicated with the ISDH. Regulations regarding remodeling, restructuring, and bed changes were also waived for the remainder of the emergency order.

Transfers between Nursing Facilities and Hospitals. On April 1, 2020, the ISDH issued guidance, consistent with the CDC and developed with Indiana providers, to guide hospital to nursing home transfers. The guidance allowed for local policies to be developed to over-ride state guidance if resource shortages warranted. Guidance stated that residents should not be transferred to the hospital for testing alone (which could be carried out in facility by the ISDH strike teams), but only if medical needs and patient advanced directives warranted hospitalization. “LTCFs are expected to accommodate hospital discharges of patients regardless of their COVID-19 status. However, local conditions will vary with LTCF capacities to care for presumed or confirmed COVID-19 patients. Hospitals and LTCFs must communicate about resource availability prior to admission/readmission to provide patient care while reducing risk of virus spread.” (www.isdh.gov). Patients could be transferred to the nursing home if symptomatic but negative. However, persons with pending COVID-19 tests could not be transferred until test results are known unless hospital capacity necessitated. Patients who were positive but meet

criteria for discontinuation of precautions could be transferred. Patients who were positive and required isolation could have been transferred to facilities who were ready to properly isolate and care for the patient, and ISDH had survey teams ready to assist facilities to achieve readiness as requested.

One day later, on April 2, 2020 a Blanket Waiver was issued by the Indiana Health Commissioner noting that a facility may not transfer a resident unless it was doing so to provide adequate care and/or remain within CDC guidelines for the management of COVID-19. In short, the statement that the transfer must be due to immediate medical needs was amended to note that it may also be because of the facility's emergency response efforts to the pandemic.

On April 13, 2020 the ISDH communicated CMS guidelines that transfer or discharge of residents between facilities for the purposes of cohorting may occur, but if any transferring involved a non-certified facility the ISDH must be notified. In compliance with this, on April 14, the Indiana State Health Commissioner issued an order allowing for the transfer, discharge or transport or relocation of any residents necessary to reduce the risks of COVID-19 in the nursing home population, protect residents who are negative for the disease, and best serve isolated residents who have tested positive. This order included movement to hospitals. The order allowed for the establishment of COVID-dedicated units within facilities. Authors were not able to locate public reporting of how many residents, where, or when residents, may have been transferred under these policies.

Staffing and Staff Shortages. A number of efforts were initiated by the ISDH to address potential staff shortages during the pandemic. On March 6th, 2020, in response to an emergency declaration by the Governor, the Indiana Health Commissioner ordered a waiver of tuberculosis screening for paid and unpaid employees of nursing homes and residential care facilities during the time that the emergency order is in effect. Also in response to the emergency order, the Indiana Health Commissioner permitted nursing homes to employ "personal care attendants" (PCA) to perform defined care procedures as an accommodation for work increases and staff shortages due to COVID-19. The PCA position is temporary, only in place during the emergency order, and requires an 8 hour training course. The waiver was later amended to include minors 16 and older. An additional waiver was initiated by the Indiana Health Commissioner on March 23 which allowed persons not otherwise permitted to provide dining assistant services to function as resident dining assistants if trained in feeding, diets, infection and safety by a licensed professional and prohibited from assisting residents with high-risk feeding situations. Additionally, on March 23 the requirement for an employee physical within a month of employment was waived.

In a similar manner, on April 18th a temporary blanket waiver was issued allowing for the "temporary nurse aide" program offered by the American Health Care Association to be temporarily approved by ISDH as a nursing aide training and competency evaluation program. Every facility that uses a temporary CNA approved through this program is required to notify the ISDH of their use, and provide a competency assessment/ skills check off.

In regards to staff being unable to work due to illness or contact, on March 18th, staff who developed symptoms were advised to call the ISDH to report symptoms, and remain off of work until 3 full days with no fever, no symptoms, and at least 7 days since symptoms first appeared. Data regarding how many staff were symptomatic was not able to be located in publicly available data sources. On May 8th an inservice was held to describe moving from a test based return to work policy to a symptom based return to work policy, and that staff must be symptom free for at least 10 days from when symptoms first appeared prior to job re-entry. Language about a test based strategy for such decisions was removed from guidance. Public reporting of number of staff not working by date or staff shortages was not available through state resources. Federal data indicated on June 7, 2020 that only 66 nursing facilities reported a shortage of nursing staff.

Balancing need for social interaction with restriction of visitation and communal activities.

Guidance was issued by the ISDH, based upon Center for Medicare and Medicaid (CMS) QSO-20-14-NH that “All facilities should restrict visitation of ALL visitors and non-essential health care personnel.” Guidance issued on March 15, 2020 went beyond nursing homes to include residential care facilities, assisted living facilities, housing with service establishments, intermediate care facilities including group homes, rehabilitation hospitals, and state and freestanding psychiatric hospitals. Exceptions were allowed for compassionate care situations, primarily end of life, but only on an individual basis and with careful screening of the visitor. Symptomatic visitors were not permitted visitation, even in end of life situations. After screening, visitors were restricted to a specific location, such as a resident room, and required to wear personal protective equipment and use proper hand hygiene. Additionally, group dining and activities were to be cancelled, both within and outside of the facility; active resident screening for fever and respiratory symptoms was to be implemented; and residents were advised to practice social distancing and hand hygiene. Posters were provided from ISDH to facilities to communicate guidelines, and facilities were advised to promote video and phone calls among residents to reduce social isolation.

On March 22nd, 2020, facilities were advised to strongly discourage voluntary resident leaves of absence citing risk to resident, and to other residents upon return to the facility. The ISDH issues allowance that if a resident insisted upon a leave of absence the facility may consider them a significant risk and discharge them per ISDH guidance. The facility medical director was allowed to issue a no leave policy, and if a leave was taken the resident would be considered outside of medical advice and would be discharged. If allowed to return, isolation must occur. Leave of absences did not include hospital or therapeutic leaves. A March 26th Blanket Waiver waived the regulation “visitor’s rights” to remain in compliance with CMS guidelines for COVID-19.

In an effort to encourage technology-based interaction, the ISDH communicated the Civil Money Penalty Reinvestment Application for Communicative Technology program, allowing applicants to submit projects for funding that would provide technology to reduce the negative impact of visitation restrictions. It is unclear how many or what type of projects were funded at this time. On April 28th the ISDH issued a Family Outreach email address, familyoutreach@isdh.in.gov, for an individual to report any problems getting information about a loved one in a nursing home related to COVID-19. The emails were directed to state surveyors, the then individual contacted, and unresolved issues sent to the state ombudsman office. Additionally, on May 22nd the Division of Aging issued a survey surrounding availability of technology to promote social connectivity in nursing homes in order to better assess the availability of connective technology for nursing home residents. Results of that survey were not publicly available to the best of our knowledge.

In an effort to re-open nursing homes to visitors and group activities, the Indiana Back on Track plan was announced on May 11, 2020. The plan mirrored the 5 step re-opening plan for the state as a whole. Although the overall staged plan allowed for opening of business, visitation to long term care facilities remained closed until at least stage 5, when guidance is planned to be re-evaluated, at the earliest July 4, 2020. (See below for updated guidance). In regards to services within facilities, some areas remained closed to nursing homes that opened throughout the state. For example, hairdressers were not allowed in nursing homes in stage 2 (early May depending upon location in the state), although they were allowed to open in the wider community. Gym equipment was allowed to be used by one individual at a time if cleaned after each use. Dental and Podiatry services were allowed if viewed as essential to health, although telehealth continued to be recommended if possible. Communal dining was allowed to resume in facilities with no active cases of COVID-19 in the past 14 days, and only if social distancing guidelines can be maintained. Residents could not share food, and hand hygiene needed to be offered before returning to their rooms. Group activities remained canceled.

Guidance was issued on June 3rd allowing outdoor visitation for facilities who had not had a COVID-19 case originating in the facility in the past 14 days. Visitors must be scheduled in advance and observe precautions such as social distancing and mask wearing. The state also issued guidance allowing families to serve as or designate essential dementia caregivers who could come into the facility to provide additional support to these residents. A negative COVID-19 test was required for these caregivers.

Guidance was issued on June 29, 2020, which required all facilities to offer outside visitation options for all residents, unless a new COVID-19 case had developed within the past 14 days. Indoor visitation was not required, but allowed, as of July 4, 2020.

FINANCIAL SHOCKS AND STRATEGIES FOR RESILIENCE / REPORTING

Financing changes. Reimbursement strategies to assist facilities. In addition to federal reimbursement policy changes, the state of Indiana issued a number of amendments to their Medicaid policies. On March 24th changes were made to the value based reimbursement program that amended advanced care planning requirements, most notably amending training requirements for staff (Indiana Health Coverage Bulletin, March 2020). On April 17, 2020 the state instituted a 4.2% Medicaid rate increase for all facilities effective March 1, 2020, to offset costs of COVID-19. In addition, a 2% rate increase was issued May 1 for facilities who attested that they are “COVID Ready” by meeting the following criteria: follow ISDH guidelines for COVID-19 preparedness; follow ISDH Long Term Care hospital transfer guidance or have developed a mutually agreed upon plan with local hospitals for admission and readmission of COVID-19 residents; follow ISDH communication guidelines; accept COVID-19 admissions and transfers; share complete COVID-19 status information with transportation providers serving residents; follow ISDH reporting requirements for new COVID-19 cases and deaths involving residents and staff. An additional [\\$115 per resident per day](#) add on was also provided for any facility qualifying as COVID ready that also billed for treatment of a COVID positive, symptomatic resident.

Transparency.

On April 8, 2020, the Indiana State Health Commissioner required that all laboratories report all negative, as well as positive (previously required) results to the state. All long term care facilities were required positive COVID-19 results for residents and employees within 24 hours of the positive result, as well as all COVID-19 deaths or suspected deaths (resident or employee) within 24 hours. Deaths must be reported regardless of where they occurred and within 24 hours of facility knowledge.

On April 9, 2020, facilities were notified of an online reporting tool, in the form of a RedCap survey link, to report cases and deaths in a timely manner to ISDH. On April 20th an updated version of the survey was released which allowed facilities to enter demographic information about the facility once and then only resident information after that to expedite reporting. On May 18 requested feedback from facilities in the form of an online survey regarding the challenges and feasibility of testing all staff at nursing homes over a 2 week period.

As was noted in the introduction of the case study, Indiana is currently only reporting the number of positive cases and COVID-19 deaths in aggregate, [as highlighted in media coverage of televised ISDH updates](#). A number of media organizations have begun investigations due to public outcry from families and advocacy groups, one is noted here: <https://www.wthr.com/article/new-search-tool-reveals-covid-19-cases-deaths-indiana-nursing-homes>. The NBC affiliate in Indianapolis that has been investigating transparency of nursing home COVID-19 data in Indiana filed a complaint with the Indiana Public Access Counselor on April 28, noting the right of public to have access to the COVID-19 nursing home level data. The response from the ISDH indicated that they are unable to generate facility specific numbers because “The computer program ISDH uses to collect long-term care facility information does not generate a report with running totals for each facility for either COVID-positive cases or COVID-related deaths. To generate a list of all facilities with their cumulative case and death counts would require an ISDH employee to create a new record by manually analyzing information in the reporting

system and to continually analyze it to keep it updated... ISDH determined that it does not have records containing the information requested, and that the Access to Public Records Act does not require ISDH to create a document responsive to his request", and noted that ISDH does not have time to carryout such requests. An additional argument given by ISDH for not releasing nursing home specific data was that as of May 4th facilities were required to communicate COVID-19 data to family members daily, and that facility driven communication is more efficient, private and appropriate. Notably, on May 18, 2020 American Senior Living Communities, a large nursing home corporation operating in Indiana, released their facility specific data in response to public requests. Similarly, Hamilton County, located in the Indianapolis Metro area, released nursing home specific data also. There is continued concern surrounding the discrepancy between CMS data available at www.cms.data.gov and local sources such as county, corporate, or media-obtained data, and the confusion it may cause.

The State has collaborated with researchers at Regenstrief Institute to develop publicly facing dashboards, including graphs and maps, for COVID-19 which are updated daily. These include overall cases, deaths, and tests which can be broken down by day and by county. Demographics, including race and ethnicity, are also reported. ICU usage, ventilator usage, and hospitalizations are reported. As noted above, nursing facility data is reported in the aggregate and updated weekly.

CHANGES, NEEDS, AND CALLS FOR ACTION

As we shift into the next phase of managing the ongoing reality of COVID-19 in nursing facilities, there are multiple areas where the State can and will support. In the near term, ISDH will be evaluating data from the all staff testing effort in June as well as other data sources on COVID-19 infection rates across Indiana, to make recommendations about the frequency and focus of ongoing testing of nursing facility staff. These recommendations should include plans for the logistical, operational and financial aspects of ongoing testing. Indiana was one of the first states to open up to outdoor visitation and will be one of the first to open up facilities to indoor visitation. The mental and emotional toll on residents and families of prolonged separation strongly influenced the decision-making to forge ahead and promote safe visitation practices. Particularly given the increase in family visitors and other providers in facilities, as some aspects of life and care in facilities return closer to a "new normal," monitoring will be essential. Robust, real-time long term monitoring of data from facilities will enable the State to track any spikes in infections in nursing home settings (among residents or employees) and react with increased support and testing. ISDH is actively hiring multiple infection control nurses who will be able to provide additional support and training to nursing facilities in all public health districts in Indiana. Maintaining the state stockpile of PPE will continue to be necessary, with a continued readiness to augment supplies of nursing and assisted living facilities. Close communication and collaboration between industry stakeholders, clinical providers, and resident/family advocates in nursing facilities and ISDH continues to be essential as we move into future phases.