
IMPACT OF COVID-19 ON LONG-TERM CARE IN NORTH CAROLINA

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Authors:

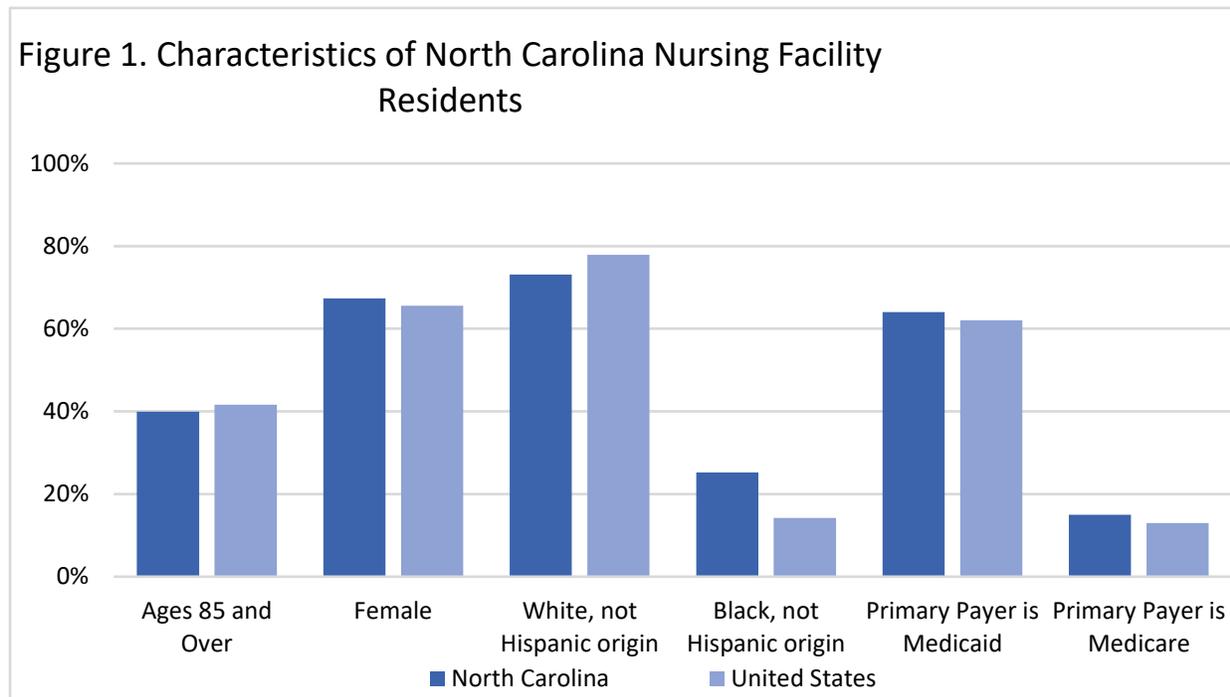
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STATE LONG-TERM CARE SETTING

Approximately 50% of North Carolina’s population is considered more vulnerable to COVID-19 than the average NC citizen. That includes people over age 65, and those with a wide range of medical conditions, such as cancer, chronic kidney disease, obesity, lung diseases. Of note, North Carolina has a higher proportion of Black residents in nursing facilities than the United States as whole. This is important to the conversation as COVID-19 has disproportionately affected POC across the US.



There are 423 long-term care facilities across North Carolina. Mecklenburg County – inclusive of the City of Charlotte – has the highest number (30) followed by Wake (24), Guilford (21), Buncombe (19), and Forsyth (15). Approximately 45,674 residents are served by these facilities with about 66% being over the age of 75. NC Department of Health and Human Services defines an outbreak as two or more people with the disease at a facility, which can include staff members, and NC noted its first facility outbreak on April 9, 2020. COVID continued to be contracted rapidly in congregate settings in NC. This included nursing homes, jails, prisons, residential care facilities, homeless shelters and migrant farmer dormitories until vaccinations were applied.

Sources:

https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fneed-extra-precautions%2Fgroups-at-higher-risk.html

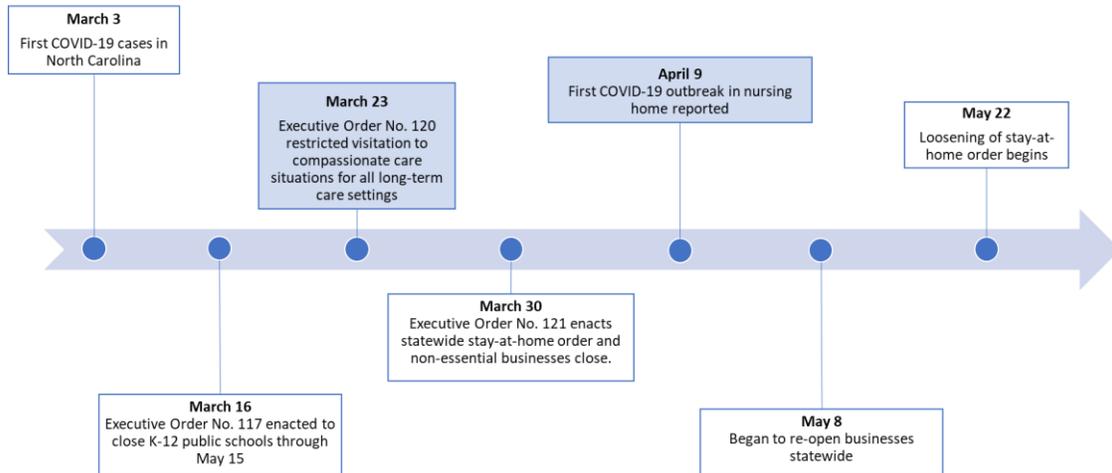
<https://medicaid.ncdhhs.gov/providers/programs-services/long-term-care>

<https://www.ncdemography.org/2021/02/15/covid-19-and-long-term-care-facilities-in-nc/>

STATE COVID-19 OUTBREAK AND POPULATION LEVEL MEASURES

Figure 2. Initial Response to COVID-19 in North Carolina

Nursing facility specific policies.



RISK MITIGATION STRATEGIES

Testing

As of June 25th 2020, broad testing of staff/residents was still behind goal. While nursing-home residents make up less than 1 percent of the state's population, they were more than half of deaths attributed to COVID-19; more than 1 in 4 residents testing positive had died according to state data available here: <https://www.newsobserver.com/news/local/article243712437.html>

According to state Health Director, Dr. Cohen testing began in July 2020. Dynamic data presentation on completed tests, 7-day average, daily difference, and positive tests is available here: <https://covid19.ncdhhs.gov/dashboard>

As of June 30, 2020, NC DHHS announced a partnership with CVS Health-Omnicare to make facility-wide testing available to residents and staff in all North Carolina skilled nursing facilities. This testing, which will allow for a baseline test of all residents and staff, began in July 2020 making testing available to the approximately residents of nursing facilities in North Carolina and to the more than 30,000+ staff. This includes 400 plus NHs, ~36K residents, 30K plus staff and has the following provisions:

- Allows for a baseline test of all residents and staff
- CVS Health will bill insurance as possible
- NCDHHS will cover additional costs of testing
- Facilities advised to follow recommendations from the CDC for repeat testing and work with community and private vendors to support ongoing testing needs.

Source:

<https://www.ncdhhs.gov/news/press-releases/ncdhhs-launches-testing-initiative-nursing-homes>

North Carolina Facilities were reporting staff shortages around 21% with shortages in nursing aides as the most common shortage type. There were not universal supplies of PPE concerning N95 masks with just over 90% reporting a supply and 77% with a one-week supply. Supply of any current eye and surgical mask protection is near 100%, which drops considerably when considering a week's supply, to 88-86%, respectively. Most striking is that in North Carolina facilities reported lacking 1 or more type of PPE. North Carolina reported higher mask shortages than many other states. At one time, NC reported N95 masks shortages at nearly twice the rate of the United States average as a whole.

NC Facilities - Shortages in staff and PPE over time

	May 25	May 31	June 7	June 14
Shortage of Nursing Staff	16.46	16.75	17.76	15.96
Shortage of Clinical Staff	2.00	2.46	5.84	1.75
Shortage of Aides	22.19	22.66	23.36	20.70
Shortage of Other Staff	13.22	8.62	11.19	10.47
Any Current Supply of N95 Masks	80.80	86.24	86.86	91.27
One-Week Supply of N95 Masks	70.32	71.01	71.53	77.31
Any Current Supply of Surgical Masks	85.29	92.63	93.19	98.50
One-Week Supply of Surgical Masks	80.80	80.84	81.02	86.78
Any Current Supply of Eye Protection	89.78	92.87	93.19	98.75
One-Week Supply of Eye Protection	79.05	84.03	82.00	88.78
Any Current Supply of Gowns	84.29	92.14	92.46	97.76
One-Week Supply of Gowns	67.58	71.18	73.72	80.05
Any Current Supply of Gloves	85.54	93.12	93.19	98.75
One-Week Supply of Gloves	84.04	90.42	89.54	93.52
Any Current Supply of Hand Sanitizer	93.27	93.12	92.94	98.75
One-Week Supply of Hand Sanitizer	87.78	90.17	89.29	93.27
No supply of 1+ PPE type	20.95	14.74	13.87	9.48
<1 week supply of 1+ PPE type	39.65	35.96	33.58	26.93
Resident Access to Testing in Facility	98.28	98.05	98.07	98.27

NC Department of Health does have a general process listed for contact tracing along with demographics of who has been hired as a contact tracer by language, race, and ethnicity (<https://covid19.ncdhhs.gov/dashboard/contact-tracing>) which is important for outreach and rapport building.

Facility direct care changes

Uniquely, NCDHHS arranged with East Carolina University School of Nursing to match Registered Nurses and Certified Nursing Assistants with facilities to address staffing shortages. They also created an emergency rule allowing nurse aides certified in other states to work as nurse aides in NC. Additionally, they increased Medicaid rate to increased staff pay, hours and training. NCDHHS is also supporting the provision of child care and other supports for essential workers including congregate care facility worker.

The following are telehealth policy modifications related to NC skilled nursing facilities. There are several new telehealth policy modifications related to North Carolina's skilled nursing facilities that have arisen. Now, patients are not required to obtain prior authorization prior to receiving services via telemedicine. Skilled facilities may now bill for an originating site facility fee when their facility is the site at which a beneficiary is located when they receive care via telemedicine from an eligible provider. Facilities may not bill for an originating site facility fee when the Medical Director or a beneficiary's attending physician is conducting a telemedicine visit. All claims are subject to audit. New policy modifications also include the option for eEligible providers, including physicians, nurse practitioners, and physician assistants. Patients are not required to obtain prior authorization prior to receiving services via telemedicine.

Source:

<https://medicaid.ncdhhs.gov/blog/2020/05/01/special-bulletin-covid-19-79-telehealth-and-virtual-patient-communications-clinical>

Facilities in NC are subject to the mandated changes in infection control approaches and planning as stated in CDC recommendations and include the following resources for facilities:

- COVID-19 Outbreak Toolkit for Long-Term Care Settings
- Long-Term Care Infection Prevention Assessment Tool
- Infection Prevention Education Resources for Long-Term Care Facilities
- Strategies to Optimize Personal Protective Equipment - Facemask
- Strategies to Optimize Personal Protective Equipment - Gowns
- IP Staffing Worksheet for Long-Term Care Facilities During COVID-19
- What to Expect: Response to New COVID-19 Outbreaks in Long-Term Care Settings

Source:

<https://covid19.ncdhhs.gov/guidance#long-term-care-facilities>.

LTC facility worker policy changes

NC was experiencing the same as across the nation with limited sick leave, not specific to LTSS -- <http://pulse.ncpolicywatch.org/2020/04/22/report-millions-of-nc-workers-excluded-from-federal-paid-sick-days-protections-as-covid-19-spreads/>

Short staffing was a problem before COVID and continuing into the pandemic <https://www.northcarolinahealthnews.org/2020/04/20/short-staffing-an-issue-at-nc-nursing-homes-marked-by-covid-19-outbreaks/>. Nearly 20% of NC facilities were self-reporting “nursing staff” shortages and approximately 24% “aide” staff shortages along with about 10% reporting “other staff” shortages. Additionally, UNC system and the state Area Health Education Councils (AHEC) created a Workforce Surge program to assist with staffing if needed.

Resident life changes

There were several changes to resident life in care facilities that were put into place at the beginning of the pandemic, albeit slowly. Many of these rules are still in place, but many are starting to get loosened. No visitor policies (which were slow to begin but were then broadly enforced) are starting to be loosened to allow outdoor visitation at some facilities.

Restricting visitation began under NC Executive Order 120 on March 23, 2020. North Carolina was the last to adopt a visitation restriction policy among the states examined. In short, visitation in skilled nursing facilities and combination homes, which are nursing homes with assisted living facilities, is restricted to compassionate care situations. Outdoor visitation is outlined in this guidance, provided that a facility is an adult care home, behavioral health/IDD, intermediate care facility, and psychiatric residential treatment facility (PRTF) with 7 or more beds.

There have also been changes made to day-to-day life inside the facilities, although these changes were also slow to begin and be enforced. One such change is the ending of communal mealtimes, which was accompanied by remain in room orders. These changes are largely continuing into phase 2, as are the serious reductions and cancellations made to activities schedules. To cope with the effects of such extreme isolation, facilities encourage virtual calls with family and one-on-one activities (while visits are still limited in North Carolina).

Sources:

<https://files.nc.gov/covid/documents/info-for/health-care/Supporting-Our-Long-Term-Care-Facilities.pdf>

<https://covid19.ncdhhs.gov/information/health-care/long-term-care-facilities#can-i-visit-a-nursing-home-or-elder-care-facility>

FINANCIAL SHOCKS AND STRATEGIES FOR RESILIENCE / REPORTING

Financing changes

NCDHHS is “providing a time-limited Medicaid rate increase for personal care assistance and home health services to help providers who support people being able to stay at home where there is less risk to exposure.” NCDHHS has allowed facilities to exceed the number of licensed beds to provide temporary shelter and services to care for residents with COVID-19.

The Coronavirus Aid, Relief, and Economic Security Act (CARES Act) provided additional funding to CMS for necessary survey and certification work related to COVID-19, of which \$80 million in new resources

will be available for states to increase surveys. The state is also providing targeted Medicaid funding to support nursing homes and adult care homes to provide intensive care needed for residents with COVID-19 and limit the spread of the virus. It is unclear whether this is state money or CARES money.

We are not seeing definitive information on changes in business models or strategies. It is likely, however, that facilities have had to shift their operations to accommodate the changes. (<https://files.nc.gov/covid/documents/info-for/health-care/Supporting-Our-Long-Term-Care-Facilities.pdf>)

Duke Health's Health Optimization for Elders (HOPE) Skilled Nursing Facility (SNF) Collaborative is comprised of a group of 25 SNFs located in Durham, NC, and surrounding counties. Member SNFs collaborate closely with an interprofessional team of leaders at Duke Health to improve the care of shared patients. The Population Health Management Office (PHMO), a branch of the Duke Health Accountable Care Organization, provides financial and administrative support for the HOPE Collaborative. This is a cohesive innovation that organizers believe is one of the first of its kind in the nation (<https://phmo.dukehealth.org/covid-19-snf>).

Transparency

All states are now under the same mandated reporting to CDC – but recently changed to DHHS -- and subject to the CMS corrective action plan (<https://www.cms.gov/files/document/qso-20-31-all.pdf>). Reporting infections/deaths for ALFs/IL/CCRC/MC is being handled at the county level in NC.

NEAR-TERM NEEDS & CALLS FOR ACTION

- 1) Patients and staff of long-term care facilities should continue to be prioritized for vaccination distribution because of increased vulnerability to COVID-19.
- 2) COVID may lead to long-lasting need for more telehealth to protect people in facilities while providing care and assessment and mitigating social isolation. We should build upon existing telehealth efforts and lessons learned. Bandwidth and device access/orientation are continued challenges.