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Mid-State Health Network

Residential Homes Crisis Plan for COVID-19

This plan is to address what the MSHN CMHSPs would do in the event that a residential provider can no longer provide services due to insufficient staffing and/or the virus outbreak in residents of the home during the COVID-19 pandemic. Preceding further escalation of the COVID crisis in the residential system, providers and CMHSPs should develop a strictly adhered to COVID residential quarantine plan, which should include identification and securing of a quarantine site(s). The recommendation is to be proactive and have a contingency plan in place as soon as possible. Affected contract providers should contact the appropriate Community Mental Health Services Program (CMHSP) to report such problems and decisions. For the purposes of this document, health care personnel (HCP) refers to all paid and unpaid persons serving in healthcare settings, including long-term care facilities, who have the potential for direct or indirect exposure to individuals or infectious materials, including body substances; contaminated medical supplies, devices, and equipment, contaminated environmental surfaces, or contaminated air. The primary care provider (PCP) is the health care practitioner who provides medical care to the individual.

Note any additional opportunities subsequently created by the approval of the 1135 waiver. Michigan Department of Health and Human Services (MDHHS) guidance is forthcoming (as of 5/4/2020).

Per the MDHHS **Guidance to Protect Residents of Long-Term Care Facilities (includes Adult Foster Care and Community-Based Residential Facilities (Upon Readmission or Current Stay**) (4/9/2020), residents without COVID-19 who require hospitalization can and should be discharged back to the facility of residence once they are clinically stable. While this document refers to elderly individuals, it can broadly be used for any age. Refer to all guidance noted in this document.

Contingency Planning for COVID-19 in a Facility

Before proceeding, please note that the Centers for Disease Control (CDC) recommendations are frequently updated, **it is recommended that the reader follow the links directly below** that contain additional up to date information:

https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html
https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-strategies.html
https://www.cdc.gov/coronavirus/2019-ncov/hcp/alternative-care-sites.html
https://www.thenationalcouncil.org/covid-19-guidance-for-behavioral-health-residential-facilities/

Residential facilities are encouraged to take additional infection control and prevention measures even if no one within the facility has been confirmed to have COVID-19. This will require some modifications to program offerings.

- To the extent possible, programs should work with individuals' health care providers to institute telemedicine appointments. Most payers are removing barriers to this allowing billing if medically necessary and documenting as if they were in the office. Blood draws and monthly injections will still need to be done in-person. For behavioral health individuals, treatment teams should consider increased frequency of engagement, including therapy, using alternatives

to in-person meetings. Individuals and staff should be reminded of the importance of follow Governor executive orders, hand hygiene, and of not touching their faces if visiting their providers is necessary.

- CDC guidance currently recommends suspending all groups and activities with more than 10 people. Communal dining and all group activities with more than 10 people, such as internal and external group activities should be canceled. Facilities should utilize non-face-to-face meeting options, such as phone, video communications, etc., to the extent possible.
- For shared bedrooms, for individuals who have not developed symptoms, ensure when possible that beds are at least six feet apart and require that individuals sleep head-to-toe.

Request staff to wear N95 masks or surgical masks. If N95 masks or surgical masks are unavailable due to a shortage of personal protective equipment (PPE), require staff to wear cloth face coverings.

Alternate Strategy: Some residents may not be able to comply with requests to wear facemasks or cloth face coverings at all times due to symptoms or other impairments. In these situations, try to encourage all other individuals nearby wear facemasks or cloth face coverings to reduce the likelihood of transmission. Questions to ask during these situations include:

- What is the goal? For example, for an agitated resident, the goal is for him or her to become calm, cooperative, wearing a mask in an area where they can't infect other people.
- What needs to be done to achieve the goal?
- How can we involve the fewest number of staff?
- Where does the person need to be?
- How can we get them there?
- Who needs to be in contact with the resident to do these things?
- Can other people leave the room?
- What people need what PPE to do these things?

1. **Keep COVID-19 from entering your facility:**
   - Ask anyone entering the facility the following questions:
     1. Have you had close contact with or cared for someone diagnosed with COVID-19 within the last 14 days?
     2. Have you been in close contact with anyone who has traveled within the last 14 days?
     3. Have you traveled in the last 14 days?
     4. Have you experienced any cold or flu-like symptoms in the last 14 days (including fever, cough, sore throat, respiratory illness, or difficulty breathing)?
   - Limit visitors to only those who are absolutely necessary and implement screening of visitors for temperature, achiness, and respiratory symptoms.
   - Restrict all visitors except for compassionate care situations (e.g., end-of-life).
   - Restrict all volunteers and non-essential HCP, including consultant services (e.g., barber, hairdresser).
   - Implement universal use of source control for everyone in the facility.
   - Actively screen anyone entering the building (HCP, ancillary staff, vendors, consultants) for fever and symptoms of COVID-19 before starting each shift; send ill personnel home. Sick leave policies should be flexible and non-punitive.

1. Screen all HCP at the beginning of their shift for fever and symptoms of COVID-19.
2. Actively take their temperature* and document absence of shortness of breath, new or change in cough, sore throat, chills, headache, and muscle aches. Newly reported symptoms include loss of smell and/or taste. If they are ill, have them keep their cloth face covering or facemask on and leave the workplace.
3. *Fever is either measured temperature >100°F or subjective fever. Note that fever may be intermittent or may not be present in some individuals, such as those who are elderly, immunosuppressed, or taking certain medications (e.g., NSAIDs). Clinical judgement should be used to guide testing of individuals in such situations. Respiratory symptoms consistent with COVID-19 are cough, shortness of breath, and sore throat. Medical evaluation may be recommended for lower temperatures (<100.0°F) or other symptoms (e.g., nausea, vomiting, diarrhea, abdominal pain, headache, runny nose, fatigue) based on assessment by occupational health or public health authorities. Additional information about clinical presentation of individuals served with COVID-19 is available.
   HCPs who work in multiple locations pose a higher risk and are encouraged to tell facilities if they have had exposure within other facilities with recognized COVID-19 cases.

- Cancel all field trips outside of the facility.

2. **Identify infections early:**
   - Actively screen all residents and staff each shift for fever and symptoms of COVID-19; if symptomatic, immediately isolate and implement appropriate Transmission-Based Precautions.
     - Symptoms may appear 2-14 days after exposure to the virus. These symptoms may include: cough, shortness of breath or difficulty breathing, fever, chills, repeated shaking with the chills, muscle pain, head ache, sore throat, and loss of taste or smell.
     - Older adults with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include new or worsening malaise, new dizziness, or diarrhea. Identification of these symptoms should prompt isolation and further evaluation for COVID-19.
   - Notify your state or local health department immediately, including contract provider report to the CMHSP (<24 hours) if these occur:
     - Severe respiratory infection causing hospitalization or sudden death.
     - Clusters (≥3 residents and/or HCP) of respiratory infection.
     - Individuals with suspected or confirmed COVID-19.

3. **Prevent spread of COVID-19:**
   - Actions to take now:
     - Cancel all group activities and communal dining.
     - Enforce social distancing among residents.
     - Encourage all residents to wear a cloth face covering for source control whenever they leave their room or are around others, including whenever they leave the facility for essential medical appointments.
     - Ensure all HCP wear a facemask or cloth face covering for source control while in the facility. Cloth face coverings are not considered PPE because their capability to protect

healthcare personnel (HCP) is unknown. Cloth face coverings should NOT be worn instead of a respirator or facemask if more than source control is required.

- If COVID-19 is identified in the facility, restrict all residents to their rooms if possible for assessment of symptoms (See #5: Identify and manage illness levels through Alternative Care Sites (ACS)) and have HCP wear all recommended PPE, if available, for care of all residents (regardless of symptoms) in the affected room or unit (or facility-wide depending on the situation). This includes: an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and gown. HCP should be trained on PPE use including putting it on and taking it off.
    - This approach is recommended because of the high risk of unrecognized infection among residents. Recent experience suggests that a substantial proportion of residents could have COVID-19 without reporting symptoms or before symptoms develop.
    - When a case is identified, public health can help inform decisions about testing asymptomatic residents on the unit or in the facility.

4. **Assess supply of PPE and initiate measures to optimize current supply:**
    - If you anticipate or are experiencing PPE shortages, reach out to your state/local health department who can engage your local healthcare coalition. Note that there is a shortage of different types of PPE and it may be difficult to locate needed supplies. Also consider indicating on your CMHSP website that PPE donations are being accepted. Additional PPE resources *could possibly* include (not a guarantee of availability or is it an exhaustive list):
        1. Michigan Local Health Department Map
        2. https://gogglesfordocs.com/
        3. https://www.suuchi.com/
        4. https://www.health-equip.com/
        5. https://www.michigan.gov/coronavirus/0,9753,7-406-98159-523641--,00.html
        6. https://www.makevictorymasks.org
        7. https://www.medsupplydrive.org/
        8. http://humanmedicine.msu.edu/News/2020/medsupplydrive-neej-patel.htm
        9. https://pmbc.connect.space/covid19/forms
    - Consider extended use of respirators, facemasks, and eye protection or prioritization of gowns for certain resident care activities. Follow guidelines to extend use of PPE: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html

5. **Identify and manage illness levels through Alternative Care Sites (ACS):**
    - Work with the local health department and Primary Care Provider (PCP) to determine level of medical care.
    - Designate a location to care for residents with suspected or confirmed COVID-19, separate from other residents. Location might be determined to be one of the following:
        1. Non-acute care: general, low-level care for mildly and moderately symptomatic COVID-19 individuals. These individuals may require oxygen (less than or equal to 2L/min), but do not require extensive nursing care or assistance with activities of daily living (ADL). This level of care corresponds to Level 5 (ambulatory care) and Level 4 (minor acuity care) individuals in medical care terminology.

2. Hospital Care**:** Mid-level care for moderately symptomatic COVID-19 individuals. These individuals require oxygen (more than 2L/min), nursing care, and assistance with ADL. This level of care corresponds to Level 3 (medical-surgical care) individuals in medical care terminology.
3. Acute Care: Higher acuity care for COVID-19 individuals. These individuals require significant ventilatory support, including intensive monitoring on a ventilator. This level of care corresponds to Level 2 (step-down care) and Level 1 (intensive care unit [ICU] care) individuals in medical care terminology.

The CMHSP will work with its local health department (Directory of Local Health Departments). The health department should be notified about residents or healthcare personnel (HCP) with suspected or confirmed COVID-19, residents with severe respiratory infection resulting in hospitalization or death, or ≥ 3 residents or HCP with new-onset respiratory symptoms within 72 hours of each other.

1. If the health care provider (HCP) worked while symptomatic (as well as a few days before symptoms developed) with symptoms consistent with COVID-19:

- The PCP should be notified and consulted for more detailed directions.
- Work with the PCP and health department to get all residents and other HCPs tested.
- Prioritize the symptomatic healthcare worker for COVID-19 testing.
- Residents that were cared for by the healthcare worker while they were symptomatic should be:
  - Restricted to their room, to the extent possible,
  - Monitored for symptoms of COVID-19each shift,
  - Required (if possible) to wear face masks if leaving their room, and
  - Cared for using recommended PPE until results of the HCP's testing are known.
- If COVID-19 is diagnosed in the HCP, residents should be cared for using recommended PPE until 14 days after last exposure and prioritized for testing if they develop symptoms.

2. If a resident shows symptoms consistent with COVID-19:

- Review the steps on page 4: **Identify and manage illness levels through Alternative Care Sites (ACS).**
- Facilities should separate residents infected or symptomatic with COVID-19 from residents who do not have or show symptoms.
- COVID-19-positive units and facilities must be capable of maintaining strict infection control practices.
  - Facility should exercise consistent assignment or have separate staffing teams for COVID-19-positive and COVID-19-negative residents.
  - For facilities with ventilator capabilities and residents with COVID-19, there may be a need for the facility to have the capacity, staffing, and infrastructure to manage higher intensity residents, including ventilator management.
- Facilities should inform residents and their families of limitations of their access to and ability to leave and re-enter the facility, as well as any requirements and procedures for placement in alternative units or facilities for COVID-19-positive or unknown status.

3. If a resident is found to have COVID-19:

    - Review the steps on page 4: **Identify and manage illness levels through Alternative Care Sites (ACS).**
    - If appropriate, ensure the resident is isolated and cared for using recommended PPE. Place resident in a single room, if possible. The facility should conduct surveillance to actively identify other symptomatic residents and HCP as well as increase assessment of residents from daily to every shift.
        - Facility should review new admissions based on their current situation and interventions being implemented.
    - Facility should counsel residents on the affected unit (or in the facility if cases widespread) and restrict residents to their rooms.
    - HCP should use recommended PPE for the care of residents in affected areas (or facility); this includes both symptomatic and asymptomatic residents. Facility should also:
        - Reinforce basic infection control practices (i.e., hand hygiene, PPE use, social distancing, environmental cleaning).
        - Provide educational sessions or handouts for HCP and residents/families.
        - Maintain ongoing, frequent communication with residents, families, and HCP with updates on the situation and facility actions.
        - Monitor hand hygiene and PPE use in affected areas.
        - Increased vitals/assessments of residents infected with COVID-19 to detect clinically deteriorating residents more rapidly (e.g., every shift). Include assessment of pulse oximetry as part of vital signs, if not already being done.
        - Educate HCP in the facility about the potential for rapid clinical deterioration in residents with COVID-19.
        - Consider increasing from daily to every shift, surveillance for new symptomatic residents among residents not known to be infected with COVID-19.
    - COVID-19 residents could share rooms with other similarly infected residents. These residents could be cohorted together in a designated location with dedicated HCP providing care.
        - Asymptomatic roommates of residents infected with COVID-19 should be considered as an exposed resident and not share rooms with other residents unless they remain asymptomatic for 14 days after their last exposure.
    - Maintain interventions while assessing for new clinical cases (symptomatic residents):
        - Ideally maintain precautions for residents until no additional clinical cases for 14 days or until cases subside.

MDHHS is actively working with other state agencies, local health departments, hospitals, and various provider associations to ensure coordination during this emergency. **The following are additional possible intervention plans to be used throughout the various contingency steps used above and subject to the approval of the appropriate authority:**

1. CMHSPs work with local health departments. Take direction from county public health departments in light of pandemic response management. Local health departments may not fully understand the scope of issues in behavioral health and/or Adult Foster Care homes, or Specialized Residential

facilities to fully appreciate the need for guidance. Depending on this relationship, the CMHSP should ensure proper conversations occur to enhance planning and support options.

2.
    a. Initiate a contact tracing process and maintain a central data repository.
    b. Ensure testing efforts are consistent with health department direction including:
        i. Tested and pending confirmation.
        ii. Tested and confirmed positive.
        iii. Recommendations to remove OVID-19 tested and confirmed positive individuals from their current residence.
3. Define and organize alternative space readiness.
    a. Vacant group homes
    b. Hotel/motel spaces; consult the statewide list for alternative hotel/motel spaces
    c. Repurpose existing spaces, such as crisis residential units (Medicaid does not pay for room and board)
4. Combine homes and operate in excess of licensing capacity if doing so does not create overcrowding in a way that prevents social distancing.
5. Combine programs into a larger facility that is not licensed and group these facilities with COVID-positive individuals, or in other instances, with COVID-negative individuals.
6. Secure another facility, including use of hotels, to act as a quarantine site. Additional facilities could include functional but closed buildings.
7. Identify additional sites considered safe to move individuals to, if risk of retaining individual is outweighed by risk of move when taking into account all factors (including risk of exposing others).
8. Ensure Licensing and Regulatory Affairs (LARA) and Recipient Rights are consulted where appropriate when residents of AFC homes or specialized residential facilities are involved.
9. Ensure informed consent with guardians and individuals, where indicated.
10. Other, as appropriate.
11. Maximize distancing by separating functions (to be identified, but could include, kitchen, dining, reduced social contact, etc.) by one room per function to minimize traffic, etc.
12. Ensure providers are consulting with and following the direction of their local health department and PCP as it pertains to whether an individual should be moved.
13. Begin informing and working with guardians and natural supports to ensure they are involved in planning and consent.
14. Review HCBS Rule impact (where applicable) and work with individuals to recommend staying home. Stay home, stay safe applies to all individuals.
15. To the extent possible, dedicate space in the facility to care for residents with confirmed COVID-19. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with COVID-19. Assign dedicated HCP to work only in this area of the facility.
16. Establish and regularly check all sources of PPE suppliers and obtain what is available.
17. Expand the use of alternate spaces to include hotel rooms along with a staffing plan to provide intervention services in the hotel (i.e. talking at socially appropriate distance, use of telehealth for regular check-ins).
    a. Have meals brought in from local restaurants.
    b. Room groupings by individual need/population.
18. One CMHSP solicit staff from another CMHSP.

19. Governor Whitmer Announces Temporary ($2 per hour) Pay Increase for Direct Care Workers (4/23/2020). Implement a $2.00 per hour "Essential Services Supplement Pay" for direct care workers in in-home behavioral health and long-term care services to Michigan's most vulnerable residents during the continuing COVID-19 pandemic. Process to be determined.
20. {Suggestion Only]. Increase CLS rate/per diem 15% plus taxes for every test-positive individual requiring care in a specialized residential home for CLS/Self-Determination arrangements for 30 days
21. [Suggestion Only]. Offering an incentive payment using General Fund dollars to families who are able to take their individual back home <u>now</u>. This would be for families that have enough natural supports to be able to do this, realizing not all individuals would have this available. Residents should not be moved to their family's home unless the risk of each option outweighs the other.
22. [Suggestion Only]. Offering an incentive payment to the provider to pay staff who would "volunteer to live at the home for 2 to 4 weeks." Amount of incentive not yet determined. [One example of incentive payments is where some jails are using two twelve-hour shifts. Staff who volunteer are not allowed to leave during this two to four-week time period. The staff work 84 hours per week (paid wage plus overtime) and are getting a $10,000 bonus on top of their wages].
23. [Suggestion Only]. Solicit volunteers within the CMHSP to live in the residential home. They would need to meet certain qualifications, but there would be immediate training to get ready in anticipation of this. They would receive some type of incentive to do so, with amount to be determined.

If any of the above steps are unsuccessful, there may have to be a mandate of work-idled staff going into the homes.

Available Hotel Information by County

MDHHS has issued a hotel listing entitled; "COVID-19 Hotel Listing Data with PIHP Regions and Updated Survey Responses." Please see this list for alternative sites for beneficiaries and call ahead to the facility to ensure availability.

Definitions

<u>COVID-19-affected resident</u>: a resident of a long-term care facility who is COVID-19 positive, a Person Under Investigation (PUI), or displays one or more of the principal symptoms of COVID-19.

<u>Health Care Personnel (HCP)</u>: The term "HCP" refers to all paid and unpaid persons serving in healthcare settings, including long-term care facilities, who have the potential for direct or indirect exposure to individuals or infectious materials, including body substances; contaminated medical supplies, devices, and equipment, contaminated environmental surfaces, or contaminated air.

<u>Long-term care facilities</u>: nursing homes, homes for the aged, adult foster care facilities, and unlicensed assisted living facilities.

Medicaid-certified nursing facility: a nursing home, State Veteran's Home, county medical care facility, or hospital long-term care unit with Medicaid certification.

Medically unstable: a change in mental status or a significant change or abnormality in blood pressure, heart rate, oxygenation status, or laboratory results that warrants emergent medical evaluation.

Person under investigation: a person who is currently under investigation for having the virus that causes COVID-19.

Primary Care Provider: the health care practitioner who provides the medical care to the individual and coordinates care with the CMHSP system.

Principal symptoms of COVID-19: fever, atypical cough, or atypical shortness of breath.

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References

CDC Coronavirus Disease 2019 (COVID-19): Considerations for Alternate Care Sites. https://www.cdc.gov/coronavirus/2019-ncov/hcp/alternative-care-sites.html

CDC Coronavirus Disease 2019 (COVID-19): Key Strategies to Prepare for COVID-19 in Long-term Care Facilities (LTCFs). (https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-strategies.html)

CDC Preparing for COVID-19: Long-Term Care Facilities, Nursing Homes (https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html)

Medicaid Services Administration (MSA) Bulletin 20-27: COVID-19 Response: Policy for Designated COVID-19 Regional Hubs 4/16/2020

Michigan Department of Health and Human Services. Governor Whitmer Announces Temporary Pay Increase for Direct Care Workers. 4/23/2020

Michigan Department of Health and Human Services Guidance to Protect Residents of Long-Term Care Facilities (Upon Readmission or Current Stay)

Michigan Department of Health and Human Services. Interim Recommendations for COVID-19 Community Mitigation Strategies 3/11/2020

National Council for Behavioral Health. COVID-19 Guidance for Behavioral Health Residential Facilities. https://www.thenationalcouncil.org/covid-19-guidance-for-behavioral-health-residential-facilities/