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BRIEF COMMUNICATION

Congregate Care in the Time of COVID-19: Proposed Best Practices from the Inside

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Introduction

As the COVID-19 pandemic continues to impact the United States and the world, it becomes increasingly important to identify practices that protect populations at increased risk for severe outcomes. Identifying those practices also provides the opportunity to address gaps in practice and implement interventions that may save lives and mitigate illness. Populations that have been disproportionately affected include those older than 65 years and those living in a variety of congregate settings.[1, 2] When we think of "long term care" we generally refer to skilled nursing facilities (SNFs) or assisted living facilities. But elder communities also include a variety of settings that range from what are called "congregate care facilities" to "life plan" or "continuing care retirement communities (CCRCs)" that may offer independent apartments but also nursing or memory care services as well. Each state regulates these communities in different ways. In California, CCRCs are licensed as Residential Care Facilities for the Elderly (RCFE) that offer independent living for individuals who may not need medical or personal assistance with living but choose to take advantage of some other services such as meal preparation, transportation, and group activities.

Because of the close living arrangements associated with congregate care, residents in these settings can be impacted by transmissible infection and lapses in infection prevention and control practices just like those who reside in assisted living or skilled nursing facilities.[3] Concern about these more independent communities led a group of individuals with long standing experience as hospital executives, long term care policy experts, pharmaceutical executives, and infectious disease and preventive medicine physicians from across the United States to come together to identify proposed best practices in these communities. What has been effective in keeping residents in these communities free of COVID-19 infection? This group met online over the course of three months, and with the help of faculty and staff from the University of Louisville, Division of Infectious Diseases and the Center of Excellence for Research in Infectious Diseases (CERID) and Project ECHO, used a framework of collaborative engagement for discussion. The ECHO Model™ consists of case-based learning and engagement for discussion and sharing best practice.[4] From these sessions, the group developed a list of proposed best practices for congregate living during the time of COVID-19, informed by perspectives from individuals living in, or having family members or friends living in, a congregate setting.

Approach

The group focused on three aspects of the spread of COVID-19: 1) Infection control, 2) testing for SARS-CoV-2, the virus responsible for COVID-19, and 3) communication to residents. Members of the group spoke with colleagues in leadership roles in retirement communities and members living in congregate settings themselves spoke with faculty, staff, and other residents in their own settings. At the same time these group discussions were occurring, the Centers for Medicare and Medicaid Services (CMS) released a toolkit outlining reported practices from long term care facilities in each state.[5] This document provided a comparative standard that the group used to identify new practices that were in use but not included in the CMS toolkit.

Infection control

In the arena of infection control, information shared with the group revealed that most facilities closed their doors to outsiders other than essential personnel, by early to mid-March. In some places, residents were still dining together several weeks later and going to group activities within the buildings. However, by April, group events were almost entirely cancelled. Meals began to be delivered to residents' rooms, and most facilities became ghost towns, with chairs and tables stacked up around the communal areas, activity rooms closed, water fountains dry, and staff wearing gowns, masks, and face shields. Seniors living alone in their rooms experienced stress and isolation after the first month, and some began to "cheat," by seeking socialization with friends or even leaving the facility for other interactions. While the reported rate of infection and death in these communities was considerably less than in nursing homes, as the months dragged on, it became apparent that just handwashing, hand sanitizers and masks could not completely control the spread of the virus. Control of infection depended on educating residents regarding risky behaviors that could lead to infection. Persuasion, recurrent testing, and quarantine after risky behaviors were all used to prevent outbreaks.

Testing for the SARS-CoV-2, also called COVID-19 testing

One of the next steps after rigorous infection control was implemented was testing of the residents and staff. In the initial months, it was not clear how often or on whom tests should be performed. Different states had different requirements, depending on geographical and regulatory environments. There was variation in testing approaches including some states requiring regular testing of all residents and staff as a condition of licensure. Other states made testing "recommended" but not "required." Some started with the testing of staff and later added residents. Because it took several weeks before testing equipment was widely available, it was late April before many communities were testing some if not all their regular staff, and some began to require contract personnel, such as nursing aides, to be tested as well.

Since independent senior living facilities are voluntary arrangements for the residents, most could not mandate that residents be tested. When testing was offered in the communities that the group observed, despite the discomfort of the nasal/pharyngeal swabbing, many agreed to testing. Results of testing in aggregate were posted in some facilities, but others shared little or no information with residents, families, and staff. This variability of information left residents uncomfortable, fearful, and unclear about how many cases had been identified in their facility. After 28 days without any additional cases, some facilities stopped testing residents, while others continued to offer testing on a regular basis, either biweekly or every month. It remains unclear, however, how many tests Medicare would approve and reimburse.

Despite these barriers, weekly or bi-weekly testing of staff has continued to this day in many facilities, with positive tests resulting in quarantining for at least 14 days, and with two consecutive negative tests before staff can come back to work. US Centers for Disease Control and Prevention (CDC) has issued and continued to update testing guidance as more information becomes available.[6] Despite clear guidance from the CDC, some facilities may not be testing at all or testing only if there is a positive case. This variability and lack of consistent approaches has led to mistrust, fear, confusion, and concern among residents.

Communication

While the group found that accepted practices in infection control were reasonably consistent throughout the communities observed, communication by management to residents took different forms in every facility. The amount and quality of communication were the least consistent of all practices. Some facilities communicated every day or week via email or paper to both residents and families; others only communicated when there was specific news to share. Some facilities communicated only with residents and not with family. For privacy reasons, names of residents who had tested positive for COVID-19 were not shared except with public health authorities, which caused rumors to proliferate throughout the communities. One facility posted a notice on the door of each resident when there had been a positive case or a death, but that method of communication was not ideal. There were mixed reactions to the communication strategies of management, with most residents expressing exasperation with whatever mode of communication was being implemented. It was clear that residents preferred more communication and detail over less. Residents with whom the group communicated expressed satisfaction with the level of care but also extreme frustration with the restrictions on their movement. The isolation and loneliness for single residents became a mental health issue that residents still do not feel has been fully addressed.

Discussion

As a result of the observations and lived experiences of the group, we would like to share the following as proposed best practices in infection control, testing and communication.

Infection control

- Plan and implement strategies to prevent the introduction of COVID-19 and promptly identify new cases in staff and residents thereby preventing the transmission of infection to others.
- Restrict visits from non-residents with clear boundaries and instructions on use of masks and social distancing for residents when they are outside their apartments. Provide residents masks as needed.
- Restrict communal activities with clear instructions and boundaries regarding the need for masks and social distancing; cancel or restructure communal activities that pose a significant risk of transmission.
- Provide financial and other support to staff in order to reduce their need to work at multiple facilities and additional jobs, thereby reducing their exposures. Examples of financial support could include: offering full time work to employees; providing 'hazard pay' in the form of salary increases and bonuses; providing financial incentives for working at only a single facility; providing housing and/or transportation allowances; providing paid time off for staff who have tested positive.
- Provide personal protective equipment to all staff for use throughout their work shifts.
- Engage the local community surrounding the facility to promote support.
- Enable good hand hygiene by installing hand hygiene stations throughout the community at strategic locations such as the entrances to residents' rooms or apartments, entrances to activity spaces, etc.
- Involve staff and residents in the goals of infection control by providing regular education and dialogue on all relevant issues including visitor and activity restrictions, handwashing, use of PPE, social distancing, recognition of COVID-19 symptoms, reasons for quarantine, etc. Utilize reminder/requirement signs in the facility; reward and recognize individual and team use of PPE.

Testing

- Develop and use an internal advisory group of residents and staff who are able to understand the testing process and purpose.
- Seek input from residents recognizing the expertise and knowledge that may exist in the resident population.
- Engage residents in planning and responding to testing, reinforcing the idea that what one resident does affects others.
- Follow CDC, state, and local health department guidelines for frequency and type of testing required.
- Identify and implement other best practices from similar communities in the region.

Communication

- Prepare and deliver frequent, complete, and transparent communication to residents and to family members as appropriate and requested.
- Recognize that trust is paramount in a crisis situation.
- Engage residents and families as appropriate to assist with elements to be included in communications.
- Embrace transparency and honesty in all communication.
- Build upon the competencies in crisis management communication when crafting messaging and selecting the trusted source(s) to deliver the messages.
- Be consistent and credible in tone, spirit, and regularity of communication.
- Ensure all communication is grounded in empathy.
- Communicate information regarding existing capacities, levels of supplies, and availability or lack of personal protective equipment.
- Use communication methods such as tele-visits or closed-circuit television to share information so all residents are able to hear the messaging and can, when able, listen to care providers to ensure all are hearing and receiving the same messages.
- Ensure that those with hearing impairment and those who speak a language other than English are able to receive the communication and messaging.
- Develop, with the assistance of residents and families as appropriate, scripts that staff can use to deliver sensitive information including the reporting of death and illness among residents.
- Understand HIPAA restrictions and apply them only as they are legally applicable.

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