WASHINGTON STATE SOCIETY FOR POST-ACUTE AND LONG-TERM CARE MEDICINE

wa-paltc

October 4, 2021

Governor Jay Inslee
Office of the Governor
PO Box 40002
Olympia, WA 98504-0002

Dear Governor Inslee:

On behalf of the Washington Society for Post-Acute Care (WA-PALTC), we are writing to review the desperate need for dedicated Covid-19 Units for Post-Acute and Long-Term Care Facilities in the State of Washington. The Board of Directors is comprised of medical experts who are boarded with the American Board of Post-Acute and Long-Term Care Medicine, as well as dedicated community stakeholders. The passion of our group throughout the Covid-19 pandemic has been to promote safe, effective, and quality care for the most vulnerable patient. Our recommendation to proceed with Covid-19 units is based on science, situational awareness of the status of hospital throughput with the Covid-19 Delta Variant, and successful outcomes from Covid-19 units in Washington from 2020 and early 2021 and from other States including New Mexico, California, and Oregon.

SUMMARY:
A PALTC Covid-19 unit serves many purposes for the benefit of public health. Covid-19 units expedite hospital discharge of clinically improving COVID-positive older adults and provide an alternative to hospitalization for those in the emergency department (ED) or assisted living facilities (ALF) that clinically do not need to be hospitalized, helping alleviate surging hospital capacities.[1] This helps to alleviate surging hospital capacities. Additionally, a SNF Covid-19 unit can be an alternate location for transfer of a resident of a facility that does not have a dedicated Covid-19 unit to help protect those existing Covid-19 negative patients.

BACKGROUND:
Currently if a patient becomes Covid-19 positive in a PALTC facility in the State, the facility keeps the patient with the goal of care-in-place. In the current set-up, there is NOT dedicated staff, there may NOT be dedicated wings to house the Covid-19 patient, and because the volume is low, caring for mixed patients with a standardized workflow is nearly impossible. In the current operational state, Covid-19 care in Washington is exceptionally unsafe for congregate mixes of patients where both long-term residents, short-term acute residents, and Covid-19 patients may be in close proximity to one another.

- In the current operational state of not having dedicated Covid-19 units, if there are one or two patients who test positive for Covid-19, the entire skilled nursing facility may be shut down by Local Public Health Jurisdictions (LPHJ) for up to two-three weeks at a time. The intermittent closing of nursing facilities is putting exceptional strain on ongoing acute-care hospitals who have not been able to decant in the current Delta surge:

[1] Verdoorn et al. *Design and Implementation of a Skilled Nursing Facility Covid-19 Unit*. JAMDA. Vol.22 Issue 5. P971-973. May 01, 2021 .

WASHINGTON STATE SOCIETY FOR POST-ACUTE AND LONG-TERM CARE MEDICINE
wa-paltc

- As a result of hospital surges, care for NON-Covid-19 patients becomes unsafe with very high numbers of patients boarding in Emergency Departments instead of being able to seamlessly move to Intensive Care Units, Operating Rooms, and Medical-Surgical floors.
- Morbidity, Mortality, and Readmissions may increase in hospitals throughout our State due to exceptionally high patient volumes and very high nurse-to-patient ratios. With each additional patient over a 1:4 nurse-to-patient ratio, there is an associated 7% increase in hospital mortality.[2]

It is imperative these units operate in a safe, effective manner to enhance the well-being of existing residents who may reside in the same building or on the same campus. Dedicated Covid-19 centers have been managed in this manner not only in the State of Washington, but in many other States with the support of government leaders, public health officials, medical ethicists, and physician-leaders who are content-experts in PALTC. In Washington State, from mid-2020 through May of 2021, there were several dedicated Covid-19 units in skilled nursing facilities and no wide-scale outbreaks that spread to Covid-19 negative residents in other areas of the facility occurred.

CALL TO ACTION:
Our strong recommendation is to proceed with dedicated Covid-19 units in select skilled nursing facilities and to approach the units with a heavily protocol-driven mindset, rigorous infection control programs, and oversight with medical experts. The best chance for following CDC Guidance for PALTC and Covid-19 positive residents is to offer dedicated units.[3] The recommendations are as follows:

1. Set up at least one Covid-19 unit, in a dedicated center, in both Eastern and Western Washington. The selection process of the center should involve rigorous standards of quality expectations:
    a. CMS 3 Star Rating or Greater
    b. Selection committee involving Physician Experts, LPHJ, and Department of Health (DOH) representatives
    c. Engaged Medical Leadership including the Medical Director of the facility with established experience in PALTC and the management of Covid-19 as well as Advance Care Planning, Goals of Care discussions, and palliative and end-of-life management.
2. A Covid-19 unit must meet certain physical plant requirements[4]:
    a. physically separate unit with dedicated entrance/exit and anteroom for PPE donning/doffing
    b. Separate unit with intake/outtake ventilation systems of which are separate and distinct from other areas of the campus where Covid-19 NEGATIVE patients reside

---

[2] https://mds.marshall.edu/cgi/viewcontent.cgi?referer=https://www.google.com/&httpsredir=1&article=1196&context=mgmt_faculty#:~:text=High%20nurse%2Dto%2Dpatient%20ratios,cardiac%20arrest%2C%20and%20accidental%20death.

[3] https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

[4] Verdoorn et al. *Design and Implementation of a Skilled Nursing Facility Covid-19 Unit*. JAMDA. Vol.22 Issue 5. P971-973. May 01, 2021 .

   c. Ventilation systems operated using guidelines from the American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) as endorsed by the CDC.[5,6]
   d. dedicated facilities (break room, conference room, laundry facility)
   e. Private Rooms
3. A Covid-19 unit must meet certain infection control requirements:
   a. reliable PPE supply and universal use (fit-tested N95 or CAPR, eye protection, gown, gloves by all providers/staff when on unit)
   b. Standardized Infection Control Training provided by Department of Health or Local Public Health Jurisdictions with knowledge of Covid-19 virology, transmission, and prevention.
   c. The requirement that only Covid-19 Vaccinated Staff/Physicians/Support Team enter the unit (i.e. no exempted individuals allowed).
   d. The requirement that if in the same physical building/plant as Covid-19 NEGATIVE patients, all NEGATIVE, Long-Term Care residents must be vaccinated. If patients are NOT-Vaccinated, they are offered a transfer to an equivalent quality facility and that all resident rights and patient autonomy are followed to ensure protections are in place.
   e. Dedicated staff on the Covid-19 unit. There are no exceptions to staff entering Covid-19 units who care for Covid-19 NEGATIVE patients (including social work, therapy, dietary, etc.)
   f. In the case of Physician and Advanced Practice Clinicians who have shared patients, if not feasible to dedicate to the Covid-19 unit, it is advised they leverage telehealth capabilities wherever feasible, and if they must round in-person in both locations, the rounding occurs for Covid-19 NEGATIVE patients FIRST, then once a Covid-19 unit is entered, the Licensed Independent Practitioner (LIP's) exits the campus and may not return until the following business day. When LIP's round in this fashion, they must do DAILY Covid-19 testing with either rapid, Antigen Testing or PCR.
4. Patient selection to the Covid-19 units should follow an evidence-based, consistent process with an equity lens and the ability to follow a limited-resource allocation process, if indicated.
5. Dedicated Covid-19 Centers should offer enhanced oversight by subject matter experts. While all centers will follow a standardized format for Department of Social and Health Services, Residential Care Services (RCS) regulation. Our recommendation is to have additional support with oversight from a Clinical Advisory Council (CAC). The CAC should be comprised of experts in medical management in PALTC, infectious disease, epidemiology, and as needed consultations from medical ethicists. This is a non-punitive, just-culture format to ensure High Reliability, Evidence-Based Practices, and a direct connection to Government Leaders to report on outcomes, processes, and accountability. Key accountabilities of the CAC shall include advising the center on evidence-based practices, offering expert consultation when difficult cases arise, and a reporting structure directly to key leaders in Government who can offer insights to the Press, Department of Health, and LPHJ.

[5] https://www.cdc.gov/coronavirus/2019-ncov/community/ventilation.html
[6] Schoen, L. Guidance for Building Operations During the COVID-19 Pandemic. ASHRAE Journal, May 2020.

WASHINGTON STATE SOCIETY FOR POST-ACUTE AND LONG-TERM CARE MEDICINE
wa-paltc

Opening these units will allow PALTC facilities to transfer their Covid-19 positive patients in order enhance the safety in current centers. Offering the ability to transfer Covid-19 positive patients will relieve stress on staff, other patients, continue to allow family visitation, and help the centers to continue to operate. Continued operation will facilitate transfer of patients from congested hospitals. In addition, this will better serve patients by slowing the spread of the virus and give them access to dedicated treatment. Finally, these centers will offer a direct connection for hospitals to transfer Covid-19 patients directly to a dedicated unit who no longer need hospital-level care. Offering the least restrictive environment for these patients improves care, enhances quality of life, and reduces cost.

Thank you for your continued support and attention to this issue. We welcome the opportunity to speak further on this topic should there be interest.

Respectfully,

Sabine von Preyss-Friedman, MD, FABIM,
President, WA-PALTC

Jessica van Fleet-Green, MD, CMD, CMD, FAAFP
Board Member, WA-PALTC

Kevin Henning, MD, CMD
Treasurer, WA-PALTC

Jason Heffernan, MS, MD, CMD
Board Member, WA-PALTC

Jonathan Raffesberger, DNP, ARNP, NP-C
Secretary, WA-PALTC

Linda Jahn
Community Member, WA-PALTC