STAY SAFE MN

Long-term Care COVID-19 Response: November 2020 Update

The Minnesota Department of Health (MDH) responded to the first COVID-19 cases by increasing outreach and support for long-term care facilities, such as skilled nursing facilities and Housing With Services (HWS) with arranged home care providers, better known as nursing homes, and assisted living facilities. The facilities provide housing, care, meals and other services as needed. Residents of these facilities include seniors, as well as younger adults living with illness, a traumatic injury, memory loss or disabilities. Together, they are some of the most vulnerable Minnesotans for getting COVID-19 and dying from it. From March through October, the department helped more than 2,320 facilities with their infection control measures. Over 435 visits (onsite and remote) have been made for infection control and technical assistance, and all nursing homes in Minnesota had regulatory onsite visits, with a special focus on infection control.

In July, Minnesota was one of the first states to roll out guidance for an Essential Caregiver program knowing the toll visitor restrictions was having on residents' overall health and well-being. This guidance allows family members and other close outside caregivers to provide care and companionship to residents in-person. In August, Minnesota rolled out broader visitation guidance to allow for more visitation, which was further revised and updated in October.

In early May, under Governor Tim Walz's leadership, Minnesota rolled out a five-point, long-term care plan focusing on seniors living in nursing homes and assisted living facilities. The plan has made facilities safer and has helped to make outbreaks an exception rather than the norm.

As of Nov. 3, data show that:

- Eight percent of Minnesota's 368 nursing homes have never had a reported case.
- Fifty-three percent of Minnesota's nursing homes currently have an active outbreak (case within the past 14 days).
- Of Minnesota's 1,692 assisted living facilities, 60% have never had a reported case.
- Only 10% of Minnesota's assisted living facilities currently have an active outbreak (case within the past 14 days).

The number of congregate care facilities experiencing an outbreak, including nursing homes and assisted living facilities, slowed significantly over the summer, but activity has been increasing:

- Early May: an average of 23 facilities per day (peak to date).
- Mid-June: an average of 6 facilities per day (minimum to date).
- Late October: an average of 13 facilities per day (recent week).

Even one death is too many. Deaths have not reached former peak levels, but they are increasing:

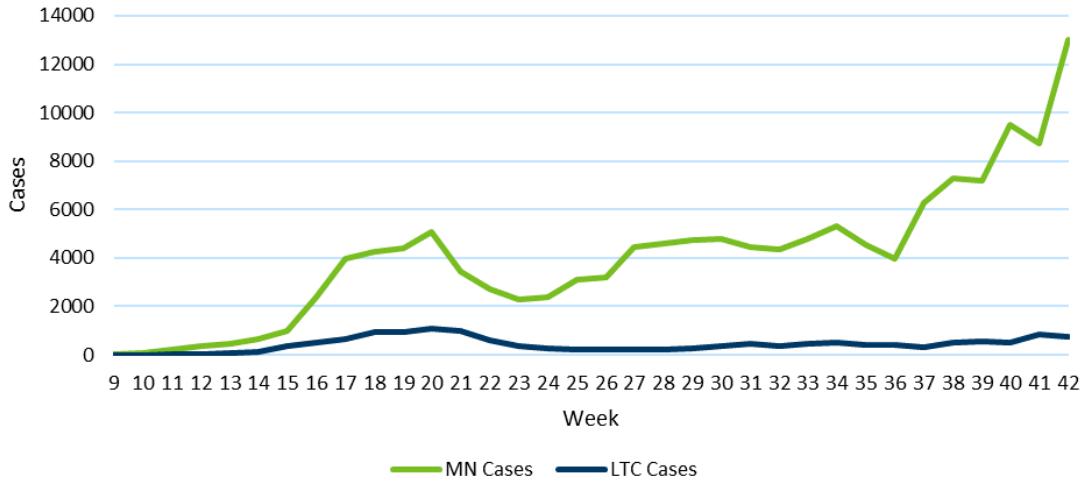
- May 17-23: 137 deaths (peak to date)
- July 5-11: 18 deaths (minimum to date)
- October 18-24: 57 deaths (recent week)

For health care personnel in **all** settings, more than a third of higher-risk exposures to a person with confirmed COVID-19 occurred outside of direct patient care—they occurred in their homes and communities. As community transmission increases, health care personnel are at higher risk.

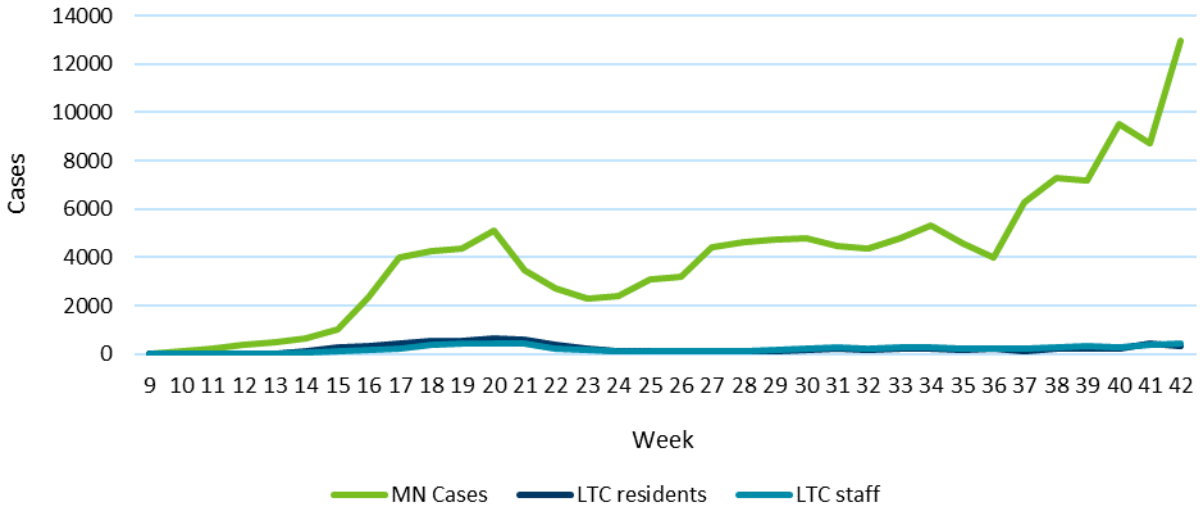
- Since the March-July period, the number of high-risk exposures experienced by health care personnel when working with residents in congregate care and long-term care settings has decreased because of improved PPE availability.
- In September, 62% of higher-risk exposures happened in household or social settings, which means that HCP are safer from higher-risk exposures at work than outside of work.

According to CMS data, 68 counties have a positivity rate above 5%. Higher rates of virus transmission in the community increase the risk for all community members and especially residents and staff in long-term care facilities. As cases continue to rise, the residents and staff in these facilities are at serious risk even as they take aggressive action to limit infections. Long-term care facilities have made great efforts to keep their residents and staff safe. However, the good work that has taken place in these settings cannot completely insulate facilities and residents from the high rate of viral transmission in the communities surrounding them. All too often, the virus enters a facility because staff are exposed in the community. As the number of cases in the community continues to increase, it is increasingly likely that these hard-won safeguards will be overwhelmed. The consequences of this can be grave.

Case counts by week, statewide cases vs. LTC-associated cases



Case counts by week, statewide cases vs. LTC residents vs. LTC staff



Long-term care five-point plan

Point 1: Expand COVID-19 testing for residents and workers in long-term care facilities

- Developed testing criteria and a process for facilities to request testing services for residents and workers. Testing capacity was initially made possible through the Minnesota National Guard and has now transitioned to health systems, physician services, and private entities.
- Partnered with laboratories within and outside Minnesota to ensure long-term care facilities have timely access to testing services. By late October, at least 40,000 tests were being done each week in long-term care.
- Transitioned from using the Minnesota National Guard for testing, to using eight contracted swabbing teams that operate around the state. Since April, the State Emergency Operations Center (SEOC) has coordinated testing for more than 750 unique long-term care facilities and 170,000 staff and residents. On average, SEOC teams swab roughly 50 facilities per week.
- Considerable specimen collection capacity remains available for facilities statewide through the SEOC.

Point 2: Provide testing support and troubleshooting to clear barriers

- Created streamlined process for facilities needing state assistance to get testing resources and support, and established a standing physician order for long-term care facilities without a medical director, so that facilities can order RT-PCR tests more easily.
- Started a nurse triage line for those facilities using the state-provided ordering physician. The triage line provides COVID-19 test results to facilities and individuals, and advises them on potential next steps after receiving test results.

- Continue to provide extensive guidance, education, and technical assistance to facilities to implement new state and federal requirements for testing, to understand how to access and when to use new testing platforms (antigen, saliva), and to address barriers that arise to facilities conducting testing.
- Established a Long-term Care Facility Testing Support Team at MDH to provide technical assistance to facilities and other parts of the state partners on when and how to test.
- Simplified antigen test reporting requirements to make it more administratively manageable for facilities.
- Worked with facilities and labs to understand issues related to testing turnaround times. Identified barriers and solutions and worked with facilities to implement.
- Developed a methodology to compile facility-wide test results from residents and staff affiliated with specific long-term care facilities. By obtaining a roster of residents and staff from facilities, this mechanism allows MDH to find and compile test results from a specific facility's residents and staff, regardless of the location of testing (e.g., if staff are tested at an outside laboratory). Regular (e.g., biweekly) state-level and individual facility reports from this complex data initiative will be produced starting in late November.

Point 3: Get personal protective equipment to facilities when needed

- Developed a system to prioritize and distribute personal protective equipment to long-term care facilities.
- Pushed out personal protective equipment to long-term care facilities in waves, starting in April. This included gowns, hundreds of thousands of facemasks, and millions of gloves.
- Provided personal protective equipment to health care providers from Veterans Affairs and the federal staffing who supported long-term care facilities experiencing staffing crises.
- Developed resources for long-term care facilities to conserve personal protective equipment.
- Provided fit testing kits to health care coalitions to support long-term care facilities with fit testing for N95 respirators.
- Provided caches of personal protective equipment to health care coalitions from the state warehouse to support long-term care facilities with personal protective equipment needs.

April Push to Long-term Care with Outbreaks, April 24-27, 2020

# of Facilities	N95s	Facemasks
444	59,440	190,230

May Push to Long-term Care with Outbreaks, May 8-15, 2020

# of Facilities	Gloves	Cloth Masks	Face Shields	Goggles	Facemasks	N95s
285	2,442,000	37,109	31,400	2,465	86,250	18,610

May Push to Skilled Nursing Facilities without Outbreaks, May 19-June 3, 2020

# of Facilities	Gloves	Cloth Masks	Face Shields	Facemasks	N95s
299	3,306,000	20,269	46,100	115,450	46,200

May Replacement N95s for SafeLife Masks in Skilled Nursing Facility/Nursing Facility, May 25-26, 2020

# of Facilities	N95s
63	18,000

June Push to Skilled Nursing Facilities June 15-23, 2020

# of Facilities	Gowns	Gloves	Face Shields	N95s
358	10,740	716,000	28,640	57,280

Replacement N95s for Safety Solution Masks, June 30-July 2, 2020

Type of Facility	# of Facilities	N95s
Skilled Nursing Facility/Nursing Facility	195	48,680
Skilled Nursing Facility/Board and Care Home	1	1,120
TOTALS	**196**	**49,560**

July Push to Assisted Living, July 4-October 28, 2020

# of Facilities	Gowns	Gloves	Face Shields	Facemasks
2,129	212,900	2,789,000	173,620	475,300

Point 4: Ensure adequate staffing levels for even the hardest-hit facilities

- Started using a scheduling software system and developed a process, with benchmarks and indicators, to report and identify when a facility is entering a crisis or is in need of additional staffing.
- Facilities with staffing needs are quickly connected to available qualified staff.
- More than 1,100 qualified health care professionals have signed up in the scheduling database.
- Since May, have filled more than 400 shifts using the scheduling software system:

Month	Shifts Filled	% of Available Shifts Filled
May	83	22%
June	112	36%
July	107	40%
August	58	31%
September	46	8%
October	137	18%

- Created a crisis staff manager team to give technical assistance to facilities. Crisis staff managers are available to address issues and connect facilities to staffing resources. At-risk facilities are identified through a special ranking and prioritization process. Outreach and education is provided to facilities to aid in the development of contingency plans, as well as crisis staffing plan prior to the occurrence of a crisis.
- Coordinated state and federal staffing assistance to long-term care facilities during May and June. National Guard teams filled a total of 45 eight-hour shifts, and federal staffing support filled a total of 1147 eight-hour shifts.
- Launched a process to deploy National Guard and federal staffing support teams to facilities in staffing crisis. Since late September, these teams have assisted seven facilities.
- Partnered with the Minnesota Department of Human Services to develop a staffing pool for facilities in need of urgent staffing assistance. DHS and the Minnesota Department of Employment and

Economic Development (DEED) helped recruit people to apply for the staffing pool by promoting the work opportunity to nearly 80,000 unemployment insurance recipients, targeting the hospitality and health care industry. A media campaign also highlighted the work opportunity and amplified the message statewide.

- The DHS staffing pool was initially implemented on Sept. 25, 2020, and to date has provided staffing assistance as outlined below:
  - Number of staff approved to work by DHS as of Nov. 2, 2020:
    - Registered nurse (RN) – 1
    - Licensed practical nurse (LPN) – 6
    - Direct Care Staff (DCS) – 87
- Total requests by facility types as of Nov. 2, 2020:

Facility Type	Number of Requests	% of Requests
Assisted Living	17	32.08%
Adult Foster Care, Community Residential Services	16	30.19%
Nursing Facility	6	11.32%
Intermediate Care Facility for Individuals with Intellectual Disabilities , 10+ people	4	7.55%
Substance Use Disorder Services	3	5.66%
Mental Health Residential Facility – Adult	3	5.66%
The following facility types have each submitted 1 application for staffing assistance: Sober Living, ICF-DD, 10 or Less People, Homeless Shelter, Housing with Services-Registered Settings	1	1.89%

Point 5: Leverage our partnerships to better apply their skills and talents

- Working with Health Care Coalitions, which include: local public health, hospitals, health care systems, emergency medical services, and emergency managers.

- Health Care Coalitions serve as a centralized regional response organization to ensure effective coordination among local and state partners, transparent and frequent communications, and fulfillment of resource requests.
- All partners support the long-term care community through a variety of preparedness and response efforts. They develop trainings, education, guidance, and policies to improve long-term care testing and staffing. They also fulfill resource requests, such as personal protective equipment distribution and patient surge capacity and discharge.
- To varying degrees across the state, local public health has provided outreach to, consultation with, and support for long-term care partners by:
  - Providing support to long-term care with testing and staffing,
  - Facilitating connections between long-term care and health care coalitions, and/or
  - Offering infection control consultation to long-term care facilities.

Congregate care case and death trends

Congregate care includes the following types of facilities including nursing homes, assisted living, memory care, transitional care units, hospice facilities, group homes, adult foster care, residential mental health and substance abuse treatment, and other communal living facilities that provide health care to their residents.

Cases

Week dates	Total number of staff and resident cases reported by week for congregate care facilities	Average cases per day by week (by date of report)
3/15-3/21	4	1.33
3/22-3/28	46	6.57
3/29-4/4	98	14.00
4/5-4/11	333	47.57
4/12-4/18	434	62.00
4/19-4/25	594	84.86
4/26-5/2	817	116.71
5/3-5/9	840	120.00
5/10-5/16	1068	152.57

Week dates	Total number of staff and resident cases reported by week for congregate care facilities	Average cases per day by week (by date of report)
5/17-5/23	1155	165.00
5/24-5/30	749	107.00
5/31-6/6	410	58.57
6/7-6/13	346	49.43
6/14-6/20	221	31.57
6/21-6/27	236	33.71
6/28-7/4	246	35.14
7/5-7/11	181	25.86
7/12-7/18	263	37.57
7/19-7/25	320	45.71
7/26-8/1	445	63.57
8/2-8/8	412	58.86
8/9-8/15	407	58.14
8/16/8/22	516	73.71
8/23-8/29	464	66.29
8/30-9/5	420	60.00
9/6-9/12	395	56.43
9/13-9/19	464	66.29
9/20-9/26	561	80.14
9/27-10/3	579	82.71
10/4-10/10	777	111.00
10/11-10/17	875	125.00
10/18-10/24	968	138.29

Deaths

Week dates	Total number of resident deaths by week of death for congregate care facilities	Average deaths per day by week (by date of death)
3/22-3/28	9	1.80
3/29-4/4	12	2.40
4/5-4/11	41	5.86
4/12-4/18	70	10.00
4/19-4/25	128	18.29
4/26-5/2	129	18.43
5/3-5/9	137	19.57
5/10-5/16	125	17.86
5/17-5/23	137	19.57
5/24-5/30	129	18.43
5/31-6/6	106	15.14
6/7-6/13	63	9.00
6/14-6/20	52	7.43
6/21-6/27	31	4.43
6/28-7/4	27	3.86
7/5-7/11	18	3.00
7/12-7/18	19	2.71
7/19-7/25	21	3.00
7/26-8/1	23	3.29
8/2-8/8	24	4.00
8/9-8/15	29	4.14
8/16/8/22	36	5.14

Week dates	Total number of resident deaths by week of death for congregate care facilities	Average deaths per day by week (by date of death)
8/23-8/29	24	7.57
8/30-9/5	29	4.14
9/6-9/12	36	5.14
9/13-9/19	20	3.33
9/20-9/26	33	4.71
9/27-10/3	42	6.00
10/4-10/10	43	6.14
10/11-10/17	50	7.14
10/18-10/24	59	8.43