PADONA UPDATES January 10, 2022

HAPPY NEW YEAR! and Welcome 2022! We are certain that each of you – as we at PADONA - are looking forward to a "different" year as we open the doors and calendars to 2022. PADONA and our boeard of directors extends wishes for a very happy, safe and healthy new year to all members and your families. We are honored to serve you as your association and humbled by the outstanding nurse leaders who comprise the PADONA membership!

Will 2022 be "the new normal" or will there be a return to "normal"? and for many we probably can't even remember what "normal" is or was. It has been a very long 2021 and a very trying and difficult 2021. We have all experienced situations and learned new verbiage and procedures that we had not previously dealt with. It has been an whole new world for many in long-term care.

PADONA is looking forward to another great year of educational webinars provided by content experts; the Leadership Development Course for our new nurse leaders (and those who want a refresher) to orient them to the role of Director of Nursing in Long Term Care and provide the gateway to certification; and the annual PADONA education Convention filled with education related to relevant topics provided by industry leaders and the networking and personal connections that last a lifetime!

PADONA thanks each of our members for the gift of your support and membership. We recognize these times have been difficult but you have maintained your membership in your nursing administration association. We are grateful, inspired and humbled by you, all you do and have done and your support.

PADONA is grateful for the opportunity to be your organization and to serve you! Your membership and support of PADONA is appreciated and we appreciate you!

It is our pleasure to serve you and assist you!

PADONA Annual Education Convention

PADONA will host the annual education **Convention in 2022 from March 29 until April 1 at the Hotel Hershey. The convention will be an in-person event!** There will be relevant educational session topics presented by professionals who are industry experts, and which will assist you with your daily operations in nursing. Attending the annual conventions will provide all of the Nursing Continuing Professional Development contact hours needed for the renewal of your nursing license as well as hours for your administrator license and renewal of your CNDLTC certification (if you are certified).

PADONA is anxiously anticipating the in-person annual education convention! The opportunity to meet with the industry experts in person, to meet and talk with vendors and to interact with peers to develop and advance professional networks is priceless. PADONA also looks forward to the prospect of sharing our stories – our triumphs and our tears - from the past two years. It will also be the occasion to celebrate the profession of nursing and the joy of nursing leadership.

PADONA looks forward to a celebration of nursing and nurse leaders. PADONA hopes that you will mark your calendars to attend the PADONA 2022 annual education convention at the Hotel Hershey!

Please watch your email for information about the annual Convention from PADONA!

PADONA Educational Needs Assessment

PADONA would like to take this opportunity to thank all members who took the time to complete the Educational Needs Assessment that was sent via email in a link to surveymonkey! We appreciate your time and the information that you provide assists us in knowing how we can assist you to fill the professional practice and education gaps that you have as nurse leaders.

PADONA Education Webinar Recordings

If you have been unable to attend the PADONA webinars or the annual education convention completed in October, with education provided by experienced professionals on relevant topics, there is an opportunity for you to receive the information from the webinars. Additionally, if you have attended the webinars and believe that the relevant and timely information from the webinars would provide appropriate education for nursing or interdisciplinary team members or could be included in facility leadership meetings, the information is available to you for a small fee from PADONA.

Please go to the **PADONA website** to review the **educational webinar recordings** that are available for purchase for your education and for use with your team members: **Continuing Education – Past Programs – PADONA – Pennsylvania Association of Directors of Nursing Administration**. Every educational webinar provided by PADONA is recorded and available on the website with handouts and recording. There are no Nursing Continuing Professional Development contact hours available for the recorded education, but the timely and relevant education is available to you and your teams.

Why pay for other educational webinars when there is so much great education available from PADONA?! Also, with the reduction in costs related to the staff development position – these recordings are a way to continue to meet the educational needs of nursing team members.

Let PADONA help you educate your staff while you reduce your workload related to education by using the recorded webinars for staff education!

Pennsylvania Department of Health Updates

At the end of the month of December, the PA DOH issued a few HANs providing information to providers of long-term care. The HANs provide guidance related to the COVID-19 pandemic, testing, isolation and visitation. PADONA is providing the HANs from the end of December for your review, and we are listing a synopsis of the HANs here for your reading and implementation as guidance in your facilities.

PA HAN 613 from December 23, 2021

- On November 30, 2021, the U.S. government SARS-CoV-2 Interagency Group (SIG) classified **Omicron** (B.1.1.529 and BA lineages) as a Variant of Concern (VOC)
- Early in vitro data suggests that **the monoclonal antibody treatment, sotrovimab, retains activity against the Omicron variant.**
- Due to the ongoing threat of COVID-19, providers are encouraged to continue to consider the COVID-19 treatment options detailed in HAN 575.
- The FDA has issued Emergency Use Authorizations (EUAs) for anti-SARS-CoV-2 monoclonal antibodies, combination therapies bamlanivimab plus etesevimab and casirivimab plus imdevimab (REGEN-COV), and monotherapy sotrovimab for use in non-hospitalized patients (age>12 and weighing>40kg), with laboratory confirmed SARS-CoV-2 infection and mild-to-moderate COVID-19 disease who are at high risk of progressing to severe disease and/or hospitalization.
- The federal government's current supply of sotrovimab is *extremely limited*. Continued use of bamlanivimab plus etesevimab and casirivimab plus imdevimab (REGEN-COV) monoclonal antibody products is recommended while reserving sotrovimab for treatment of eligible outpatients at *highest* risk who are either:
    - Diagnosed with a test that may identify a potential case of the Omicron variant (e.g., by S-gene Target Failure (SGTF) in the ThermoFisher TaqPath assay); or
    - Are present in local settings where reported prevalence of Omicron is greater than 20%; and
    - Meet criteria for administration of sotrovimab, per sotrovimab's EUA
- **Sotrovimab** is not a substitute for COVID-19 vaccination **and is not authorized for use as pre-exposure prophylaxis to prevent COVID-19.**

PA HAN 614 from December 28, 2021

Due to concerns about increased transmissibility of the SARS-CoV-2 Omicron variant, this guidance is being updated to enhance protection for healthcare personnel (HCP), patients, and visitors, and to address concerns about potential impacts on the healthcare system given a surge of SARS-CoV-2 infections. These updates will be refined as additional information becomes available to inform recommended actions. Updates include:

- Ensure that SARS-CoV-2 testing is performed with a test that is capable of detecting SARS-CoV-2, even with currently circulating variants in the United States
- Updated recommendations regarding when HCP with SARS-CoV-2 infection could return to work
- Updated contingency and crisis strategies for mitigating staff shortages

PA HAN 615 from December 30, 2021

- This version of PA-HAN 615 has been updated to reflect a correction in what is included in non-healthcare congregate settings.
- Persons who test positive for COVID-19 must isolate for 5 days. If after 5 days, the patient is asymptomatic or has resolving symptoms, their isolation period is over; however, they should still wear a mask around others until day 10.
- Persons who have been exposed to someone with COVID-19 and have received a booster vaccine or are within 6 months of receiving their primary vaccine series should wear a **mask** around others for 10 days, but do not need to quarantine.
- Persons who are unvaccinated or who are eligible (i.e., more than 6 months after primary vaccine series) but have not yet received a booster vaccine must quarantine at home for 5 days, and then wear a **mask** around others until Day 10.
- All exposed persons regardless of vaccination should test on Day 5 if possible.
- Heterologous dosing (e.g., mix-and-match vaccine products) may occur for the booster dose.
- Isolation guidance for healthcare workers can be found in PA-HAN-614.
- **This guidance does NOT apply to non-healthcare congregate settings or to persons at higher risk for severe disease. Additional guidance is underway for these populations.**

Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control (CDC) Provide Additional Information Related to the current Status of the Pandemic

The CMS and CDC completed a joint webinar for providers on January 6, 2022 to review current recommendations related to the COVID-19 pandemic. They reviewed current guidelines and directives. The webinar ended with both organizations stating they will continue to provide webinars of this type for providers regularly to assist providers through the remainder of the pandemic. The two organizations stated that additional education and transcripts from the webinar would be available (and future webinars of this type) would be available on specific websites they have set up.

PADONA is providing these websites for you from the January 6 webinar. As always, if the link does not work for you please copy and paste the URL to allow you to access the information.

https://www.cdc.gov/coronavirus/2019-ncov/your-health/quarantine-isolation.html

https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts

Quality Measures Manual

CMS has updated the MDS 3.0 Quality Measures User's Manual. The updated manual is effective January 1, 2022. This update is v15.0. The updated manual is available on the CMS website.

CMS Issues Guidance for the Interim Final Rule – Medicare and Medicaid Programs: Omnibus COVID-19 Health Care Staff Vaccination

On December 28, 2021 CMS issued a guidance memorandum (QSO-22-07-ALL) related to the vaccine mandate. This memorandum guidance does apply to Pennsylvania provider facilities because PA is not listed as one of the 25 states for which a stay has been issued. The memorandum summary includes the following:

SUBJECT: Guidance for the Interim Final Rule - Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination

Memorandum Summary

- CMS is committed to ensuring America's healthcare facilities respond effectively in an evidence-based way to the Coronavirus Disease 2019 (COVID-19) Public Health Emergency (PHE).
- On November 05, 2021, CMS published an interim final rule with comment period (IFC). This rule establishes requirements regarding COVID-19 vaccine immunization of staff among Medicare- and Medicaid-certified providers and suppliers.
- CMS is providing guidance and survey procedures for assessing and maintaining compliance with these regulatory requirements.
- The guidance in this memorandum does not apply to the following states at this time: Alabama, Alaska, Arizona, Arkansas, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Mississippi, Missouri, Montana, Nebraska, New Hampshire, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Texas, Utah, West Virginia and Wyoming.
- **Surveyors in these states should not undertake any efforts to implement or enforce the IFC.**

Vaccination Enforcement– Surveying for Compliance

Medicare and Medicaid-certified facilities are expected to comply with all regulatory requirements, and CMS has a variety of established enforcement remedies. For nursing homes, home health agencies, and hospice (beginning in 2022), this includes civil monetary penalties, denial of payments, and—as a final measure—termination of participation from the Medicare and Medicaid programs. The sole enforcement remedy for non-compliance for hospitals and certain other acute and continuing care providers is termination; however, , CMS's primary goal is to bring health care facilities into compliance. Termination would generally occur only after providing a facility with an opportunity to make corrections and come into compliance.

CMS expects all providers' and suppliers' staff to have received the appropriate number of doses by the timeframes specified in the QSO-22-07 unless exempted as required by law, or delayed as recommended by CDC. **Facility staff vaccination rates under 100% constitute non-compliance under the rule.** Non-compliance does not necessarily lead to termination, and facilities will generally be given opportunities to return to compliance. Consistent with CMS's existing enforcement processes, this guidance will help surveyors determine the severity of a noncompliance deficiency finding at a facility when assigning a citation level. These enforcement action thresholds are as follows:

Within 30 days after issuance of this memorandum, if a facility demonstrates that:

- Policies and procedures are developed and implemented for ensuring all facility staff, regardless of clinical responsibility or patient or resident contact are vaccinated for COVID-19; **and**
- 100% of staff have received at least one dose of COVID-19 vaccine, or have a pending request for, or have been granted qualifying exemption, or identified as having a temporary delay as recommended by the CDC, the **facility is compliant under the rule; or**
- Less than 100% of all staff have received at least one dose of COVID-19 vaccine, or have a pending request for, or have been granted a qualifying exemption, or identified as having a temporary delay as recommended by the CDC, the **facility is non-compliant under the rule.** The facility will receive notice of their non-compliance with the 100% standard. A facility that is above 80% **and** has a plan to achieve a 100% staff vaccination rate within 60 days would not be subject to additional enforcement action. States should work with their CMS location for cases that exceed these thresholds, yet pose a threat to patient health and safety. Facilities that do not meet these parameters could be subject to additional

enforcement actions depending on the severity of the deficiency and the type of facility (e.g., plans of correction, civil monetary penalties, denial of payment, termination, etc.).

(If 30 days falls on a weekend or designated federal holiday, CMS will use enforcement discretion to initiate compliance assessments the next business day.
3 This information will be communicated through the CMS Form-2567, using the applicable Automated Survey Process Environment (ASPEN) federal tag.
4 If 60 days falls on a weekend or designated federal holiday, CMS will use enforcement discretion to initiate compliance assessments the next business day.)

Within 60 days after the issuance of this memorandum4, if the facility demonstrates that:

- Policies and procedures are developed and implemented for ensuring all facility staff, regardless of clinical responsibility or patient or resident contact are vaccinated for COVID-19; **and**
- 100% of staff have received the necessary doses to complete the vaccine series (i.e., one dose of a single-dose vaccine or all doses of a multiple-dose vaccine series), or have been granted a qualifying exemption, or identified as having a temporary delay as recommended by the CDC, the **facility is compliant under the rule; or**
- Less than 100% of all staff have received at least one dose of a single-dose vaccine, or all doses of a multiple-dose vaccine series, or have been granted a qualifying exemption, or identified as having a temporary delay as recommended by the CDC, the **facility is non-compliant under the rule.**
- The facility will receive notice of their non-compliance with the 100% standard. A facility that is above 90% **and** has a plan to achieve a 100% staff vaccination rate within 30 days would not be subject to additional enforcement action. States should work with their CMS location for cases that exceed these thresholds, yet pose a threat to patient health and safety. Facilities that do not meet these parameters could be subject to additional enforcement actions depending on the severity of the deficiency and the type of facility (e.g., plans of correction, civil monetary penalties, denial of payment, termination, etc.).

Within 90 days and thereafter following issuance of this memorandum, facilities failing to maintain compliance with the100%standard may be subject to enforcement action.

Federal, state, Accreditation Organization, and CMS-contracted surveyors will begin surveying for compliance with these requirements as part of initial certification, standard recertification or reaccreditation, and complaint surveys 30 days following the issuance of this memorandum. Additional information and expectations for compliance can be found at the provider-specific guidance attached to this memorandum.

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Next COVID-19 Wave May be Chronic Lung Disease, Suggested in a Study

Measurable changes in lung function found after mild COVID-19 infection may indicate that clinicians should brace for a wave of chronic lung disease, experts report as the result of a study completed by Danish researchers.

The findings of the study showed a small but significant drop in certain measures of lung function and capacity among non-hospitalized patients who had recovered from asymptomatic and mild disease.

“These results suggest that even mild COVID-19 may adversely affect the lungs in a sample of relatively healthy individuals from the general population,” reported lead author Katrine K. Iversen of Copenhagen University Hospital and colleagues.

Damage to lung function following a bout with COVID-19 has been found in other short- and long-term studies as well, the authors noted. With this in mind, clinicians may do well to anticipate a possible “second global pandemic” of chronic respiratory problems, one outside expert said, as reported by the Center for Infectious Disease Research and Policy at the University of Minnesota, or CIDRAP.

The study was published Jan. 3 in the *Journal of Infectious Diseases and can be found at:* https://academic.oup.com/jid/advance-article/doi/10.1093/infdis/jiab636/6494545

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PADONA Posts Staff Needs to Website

If you are experiencing staffing needs, PADONA can assist. As a PADONA member, one of your benefits is that PADONA will post your ads for positions on our website without cost. If you are in need of a posting a staffing ad, please send the written ad to Candy Jones at cjones@padona.com and it will be posted on the PADONA website. The PADONA website is where Pennsylvania nurses and nurse leaders go to look for available positions. We are here to help you fill those needed positions.

Labor Organizations, Unions Ask Federal Court to Intervene with OSHA Protections for Healthcare Workers

Several labor organizations and unions representing healthcare workers filed suit Wednesday in the U.S. Court of Appeals for the District of Columbia, urging the court to order the Occupational Safety and Health Administration to issue a permanent standard that requires employers to protect healthcare workers against COVID-19 after OSHA announced last week that it has withdrawn some aspects of its healthcare emergency temporary standard.

The standard that OSHA adopted in June required healthcare settings such as long-term care providers to conduct hazard assessments and have written plans in place to mitigate the spread of the coronavirus, along with requiring healthcare employers to provide some employees with personal protective equipment. Additionally, the standard included social distancing, employee screening, and cleaning and disinfecting protocols.

“The unions file this petition because the agency tasked with shielding nurses and other healthcare workers from unsafe work conditions, the Occupational Safety and Health

Administration (OSHA), has failed to protect them as expressly required by law,” according to court records filed by National Nurses United, New York State Nurses Association, Pennsylvania Association of Staff Nurses and Allied Professionals, American Federation of Teachers, American Federation of State, County and Municipal Employees and American Federation of Labor and Congress of Industrial Organizations.

According to the petitioners, “OSHA does not have discretion to create a temporal hole with indefinite duration in the regulatory framework of healthcare worker protections while a pandemic rages.” The lawsuit names Labor Secretary Marty Walsh and Assistant Secretary of Labor for Occupational Safety and Health Douglas Parker.

“In failing to follow their own mandate to create a permanent standard, OSHA has put nurses, healthcare workers and the public’s health at risk of even greater harm. The Department of Labor has left nurses and their patients in serious jeopardy,” NYSNA Executive Director Pat Kane, RN, said.

The American Federation of Government Employees previously announced its opposition to OSHA’s withdrawal of the standard in a statement Tuesday.

“While we applaud OSHA for working on a permanent infectious disease standard, something our union has long fought for, we know that finalizing such a standard will take years — which is time our front-line workers do not have as the omicron variant continues to surge, resulting in thousands of new infections each day,” AFGE National President National President Everett Kelley said.

“Despite rising vaccination and booster rates, we are still in a healthcare crisis. This decision is a step backwards for healthcare workers, who are now entering year three of risking their health in service of the American public,” he added.

CDC Gives Nursing Home Workers a Big Break – if They're Boosted

Return to work restrictions for nursing home staffers that have received a COVID-19 booster shot has been significantly shortened when compared to vaccinated or unvaccinated counterparts under new federal health guidance designed to push more healthcare workers to receive the additional dose.

"We know how challenging nursing homes and all long-term care facilities have been in keeping their staff healthy and working. If you're boosted, you can keep working," Arjun Srinivasan, M.D., association director for healthcare associated infections at the Centers for Disease Control and Prevention, said in December during a provider stakeholder call hosted by the Department of Health and Human Services.

"You can not only serve your patients but you can also help your fellow staff members," Srinivasan added.

The updated guidance was released days before Christmas by the CDC in response to concerns about the increased transmissibility of COVID-19 omicron variant. The quarantine and isolation recommendations take into account a healthcare worker's vaccination status if they are exposed or infected with the disease. It also takes into account a facility's staffing challenges it might be facing.

The staffing considerations are broken down into three categories: convention, contingency and crisis.

For boosted, vaccinated or unvaccinated healthcare workers infected with COVID-19, the recommendations call for staff to isolate for 10 days or 7 days with a negative test or improved symptoms.

Under contingency staffing, when a facility might have several workers out sick, the guidance allows for workers to be isolated for five days with or without a negative test if they're asymptotic or mildly symptomatic and their condition has improved. Under crisis staffing, there are no work restrictions with prioritization considerations of asymptotic and symptomatic workers.

The work restrictions for staff exposed to COVID-19 depends on if they are boosted or not. For boosted workers, there are no work restrictions under both contingency or crisis staffing considerations. Under conventional, there are also no restrictions if they test Day 2 are between five and seven days after exposure.

"If you are not boosted, we do recommend that you be restricted from work for either 10 days if you're not going to be tested or for seven days with a negative test," Srinivasan said.

He explained that the different recommendations underscores the importance of why healthcare staff must get boosted.

"What we know is that if you're boosted you are at a much, much lower risk of then contracting COVID," he explained. "We feel comfortable saying if you are boosted and you've been exposed to someone with COVID, you do not need to be restricted from work."

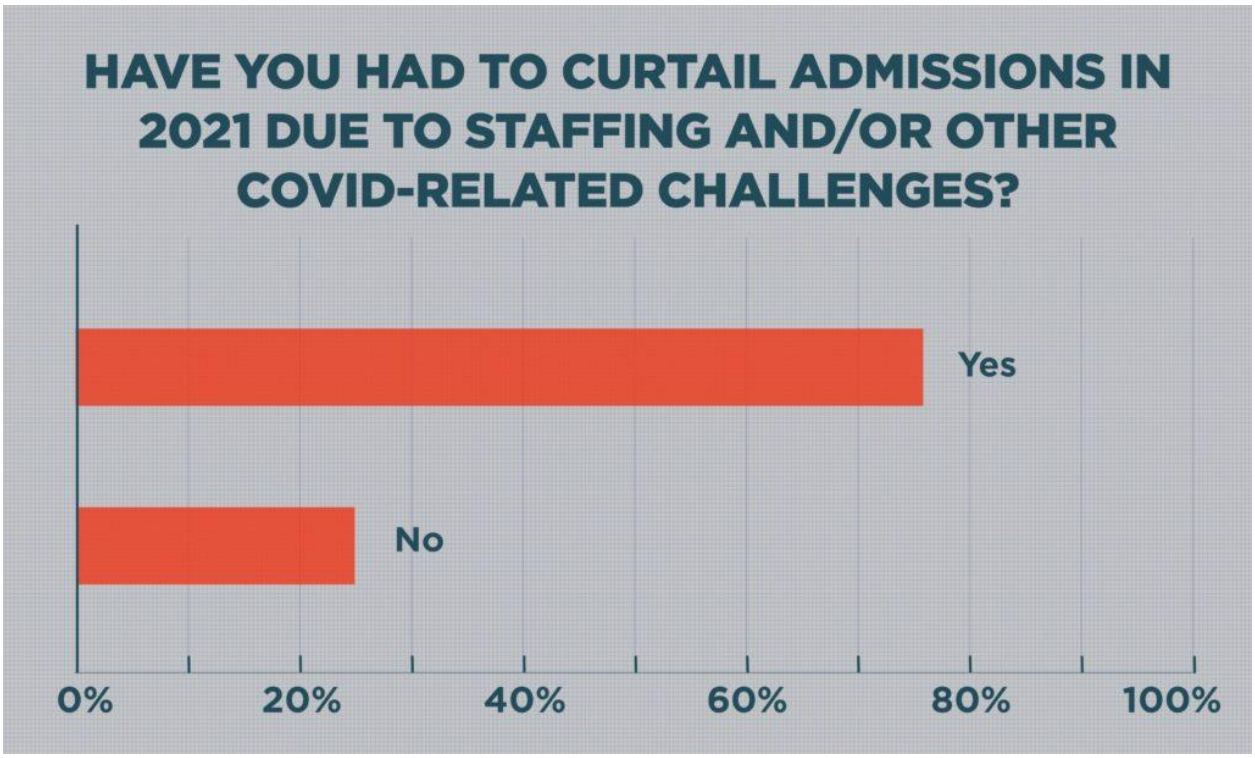
Outlook 2022: With Facility Doors Remaining Closed, Nursing Homes Hope New Services will Open Opportunity

Nearly 60% of skilled nursing managers expect they'll have to continue restricting admissions in 2022, as census challenges fueled by staffing shortages and COVID-19 surges continue to threaten facilities' viability.

In addition, about 45% of respondents in the *McKnight's* 2022 Outlook Survey said they expected their skilled nursing occupancy to increase this year, but more than 12% said they thought it would decrease.

Notably, 50.2% said skilled census likely wouldn't match pre-pandemic levels until 2023 (28.4%) or 2024 or later (21.8%).

Those views were captured by *McKnight's Long-Term Care News* in a survey of 317 nursing home owners, administrators and top nurse managers. They responded to email questionnaires between Dec. 10 and Dec. 30.



Nearly three-fourths of respondents (74.8%) said they had had to restrict admissions in 2021, a rate 28% higher than an industry-wide survey conducted by the American Health Care Association / National Center for Assisted Living in September. At that time, AHCA reported that 58% of providers were limiting admission, but staffing pressures have since escalated. COVID-19 waves fueled by the delta and omicron variants also forced hospitals to again start limiting elective surgeries and reduce referrals.

Those factors, along with concerns about reimbursement, compliance changes, and rising costs, left respondents feeling largely pessimistic about the year ahead.

Nearly 57% said they were less optimistic about the industry's prospects in 2022, with another 24.2% taking a neutral stance. Only 18.8% said they felt more optimistic.

“Our economic recovery has been slow, and many providers are having to limit the number of residents they serve due to staffing and financial challenges,” AHCA reported. “Not only is a historic labor crisis impacting our ability to recover, but we’re also dealing with price gouging by temporary staffing agencies and inflation increasing other operating costs. Now, another surge due to Omicron threatens our already exhausted frontline caregivers and battered profession. It is no wonder that more than half of providers are less than optimistic about the coming year. “

In a separate NIC MAP Data Service skilled nursing report released Dec. 30, occupancy had rebounded through October to 75.4%. That’s above the pandemic-low of 71.6% but still far from the pre-pandemic occupancy rate of 85.8% in February 2020.

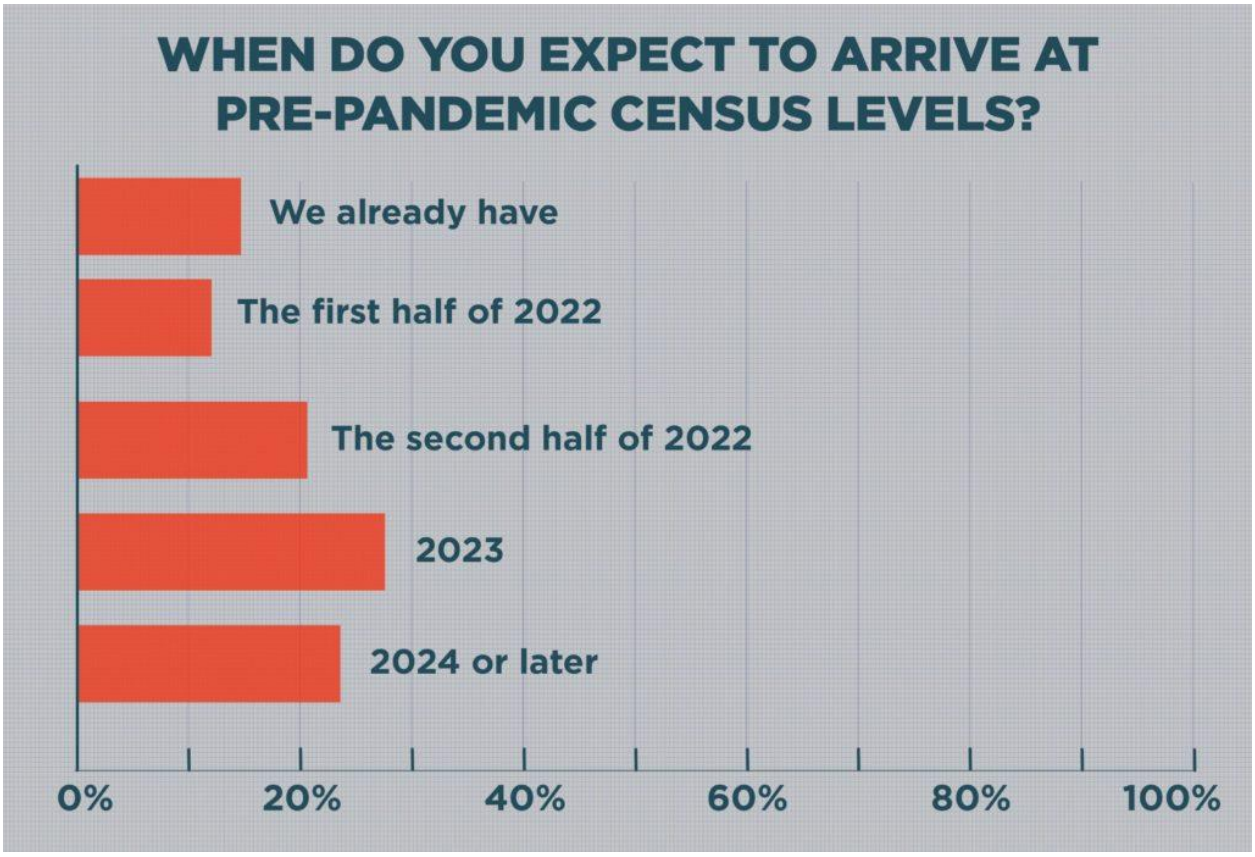
“Sustainable occupancy levels can vary by operator,” NIC Principal Bill Kauffman stated in early January. “However, in general, occupancy is still at low levels, and many operators will be unable to sustain operations if their cash flow is below break-even levels for an extended period of time.

Amid the current climate, limited referrals from COVID-strapped hospitals may continue to be a secondary issue, behind coast-to-coast hiring and retention challenges.

“There is much discussion from many operators that the occupancy challenges are not a demand issue, but a staffing/labor issue,” Kauffman added. “Many operators are unable to find or retain the staff to accept new admissions.”

Signs of hope

Amid the negative implications in the 2022 Outlook Survey responses, there were some reminders of positive change: Fifteen percent said their buildings had already returned to pre-pandemic census levels, with about 12.4% expecting to do so in the first half of this year. Another 20.5% expect to get there in the second half of 2022.



Returning to full operations also has been a relative bright spot for many respondents. In late December, 26% said they had already resumed all normal activities, including group dining, visitation and day trips. Another 37.6% anticipated they will reinstitute all of those activities — crucial for combating isolation and attracting prospective residents — sometime in 2022.

And many providers — nearly two-thirds — said they stand ready to add new or expanded services in 2022.

Specialties such as dialysis, ventilator units, pain management and certified clinical programs were the types of service lines most likely to be added, at 34.7%. Specialties — particularly those connecting skilled nursing with hospitals or additional clinical staff — grew in popularity during the pandemic, when hospitals continued to become less likely to refer traditional orthopedic patients for in-patient rehab.

The addition of ancillary services, such as in-house pharmacy, therapy and home health practices, came in second at 21.77%. Adding services is one way for nursing homes to increase their staying power.

Younger Long-Stay Residents Hospitalized at Twice the Rate of Older Residents Reported a Study

Long-stay nursing home residents aged 60 years and younger have double the odds of a hospital transfer when compared to residents aged 80 years and older. They also present with a different clinical profile, a new study finds.

The analysis of federal acute-care transfer data from nearly 1,200 long-stay residents showed that annual rates of hospital transfers decreased with age. Transfer rates were highest in the younger-than-60 group, and declined slowly between ages 60 and 80. After age 80, this decrease in transfer rates accelerated.

The findings refute the notion that hospital transfer rates increase along with age and fragility. They also offer a glimpse into the needs of the significant population of younger people now cared for in nursing homes, the researchers said. About 1 in 6 long-stay nursing home residents in the United States are younger than age 65, reported study lead Wanzhu Tu, Ph.D., of the Regenstrief Institute and the Indiana University School of Medicine.

Younger residents also were found to experience more sepsis, daily pain and anemia, and more often required dialysis or tube feeding than the older cohort. Older residents, meanwhile, had a higher rate of cognitive decline, dementia and diabetes. The older residents also were more likely to have an advance care planning preference for comfort care in life limiting situations, the researchers noted.

“Knowing and understanding age-specific rates of hospital transfers, as we now do, could support benchmarks for care provision and help in the design of targeted strategies to reduce hospital transfers that better recognize and address the diverse needs of nursing home residents of different ages, especially younger residents,” Tu said.

Full findings were published in the journal *Age and Aging* and can be found at:
https://academic.oup.com/ageing/advance-article-abstract/doi/10.1093/ageing/afab232/6430100?redirectedFrom=fulltext

Researchers Call for Family Caregivers to be Better Incorporated into Nursing Home Workforces

Providers, patients and policymakers should better incorporate informal caregivers into skilled nursing facilities to enhance professional caregivers' capabilities and efficiencies, according to University of Pennsylvania researchers.

Family members and other caregivers who support community-dwelling seniors with multiple activities could be used to lessen the blow of severe staffing shortages providers have faced during the pandemic, they said in a paper published in *Health Affairs* Tuesday.

"Unmet need likely increased during the pandemic because of worsening staffing shortages and visitor bans restricting informal caregiving," wrote authors Norma B. Coe and Rachel M. Werner. "Together, this is suggestive evidence that nursing homes and residential care facilities might not be staffed or equipped to provide all of the care required."

Acknowledging the decrease in care for some residents amid COVID-19-related quarantines and federal visitation restrictions, many states moved over the last year to increase "essential" caregivers' access to nursing homes. Lawmakers have emphasized the need for caregivers to provide emotional support, as well as assistance with daily chores ranging from hygiene to hand-feeding.

In Coe and Werner's investigation, using data from the 2016 Health and Retirement study and 2015 National Health and Aging Trends study, nursing home and residential care facility residents needed the most help with household activities, mobility needs and self-care — with more than half of nursing home residents receiving informal care across all three activities.

Researchers found that 75% of nursing home residents needing help with mobility had those needs met by informal care providers.

Self-care needs, including help with eating, bathing, using the toilet and dress, existed for 80% of nursing home residents. Assistance with these tasks from informal caregivers was high among nursing home residents, with 76% saying they needed help from informal caregivers with these tasks, findings showed.

Investigators said that the typically high prevalence of informal caregiving in nursing homes could be one explanation for the discrepancy between the perceived nursing home staffing shortages and recent findings that staff time per patient was stable during the pandemic.

"If staff members were expected to absorb the care tasks that had previously been provided by family members, their workload could have increased dramatically," Coe and Werner wrote. "Staff members might have also needed to provide help with teleconferencing with family, friends, or medical care providers during the pandemic, as the majority of residents needed assistance with traditional telephone use in non-pandemic times and informal caregivers often provided that help."

They added that the findings could mean facilities aren't staffed or equipped enough to provide all of the care required. They suggested family caregivers could be integrated into a resident's care team in several ways, including through formal training and the adoption of more explicit integrated care models in which formal and informal care providers cooperate.

"This invisible workforce provides considerable front-line work for residents," they concluded. "Policies and practices that incorporate informal caregivers into the care delivery system could benefit care recipients, caregivers and staff members in residential facilities and nursing homes."

Full findings can be found in the January edition of *Health Affairs* at:
https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2021.01239?journalCode=hlthaff

Staff Support Outweighs Wages as Turnover Solution, Nursing Home Study Finds

A people-oriented work environment with tangible staff supports is key to minimizing turnover and care disruptions in nursing homes. In fact, direct care providers say it's often more important than compensation, according to a new study.

Researchers from the University of Michigan and the Department of Veterans Affairs at Ann Arbor Healthcare System interviewed direct care RNs, LPNs and CNAs, as well as residents' family members about strategies for reducing staff attrition and its consequences.

Person- and resident-centered care has been a core nursing home concept for two decades, but the study results showed that staffing problems work against this ideal, lead author Sarah L. Krein, Ph.D., RN., reported.

"Although better wages were mentioned, it was not viewed by most participants as a primary factor to reduce turnover," Krein said. "Rather, family members as well as direct care and administrative staff all identified the need for staff to feel appreciated and have the support they require as critical to decrease turnover and minimize disruptions in care delivery."

"While some interviewees mentioned bonuses or incentives, it was generally in the context of staff recognition or appreciation rather than as additional compensation," Klein added.

Direct care workers in the study talked about the importance of work environments in motivating staff to remain on the job.

"I don't think that a wage increase, too much, would affect the turnover," one direct care worker said. "… I mean, higher pay could be a motivator for some, but I know most would rather prefer a better work environment."

Another direct care worker pinpointed constant overwork and scattered support from senior care providers as an important issue: "If you're burning the candle at both ends because you're always short-staffed … you don't get any help from the nurse, then … and it's just like that constantly, I mean, the money's not worth it."

Administrative staff were on the same page as their direct care colleagues. As one administrator said: "So management plays a huge role in turnover, and it's about having a rapport and, you know, respectful relationship amongst each other … So when you feel like that your boss has your back, you know, you're more likely to stay where you're at."

Study respondents also offered ideas for alleviating the well-known consequence of high staff turnover rates: inconsistent care provision. New staff training and adequate training time is key to solving this problem, they said.

New staff must get to know the resident as a person, including likes, dislikes and preferences, they said. Many family members recommended that facilities post signs in residents' rooms to communicate preferences or specific care requirements to direct care providers, for example.

Full findings with additional suggestions from study participants were published in *JAMDA and can be found at:* https://www.jamda.com/article/S1525-8610(21)01063-X/fulltext#%20

Antigen Tests Reported by FDA as Possibly Less Sensitive to Omicron

Currently available antigen tests may not be able to detect the omicron SARS-CoV-2 variant as well as they could detect previous variants, an early laboratory study has found.

Antigen tests "do detect the omicron variant but may have reduced sensitivity," the Food and Drug Administration reported in a Dec. 28 website post. The agency is studying the performance of the tests with patient samples containing the omicron variant in collaboration with the National Institutes of Health.

In the meantime, antigen tests are still federally authorized for use as directed, the FDA said. They are generally less sensitive than molecular tests. But their overall ability to detect infections, especially as part of serial testing programs, has been an infection control-plus for long-term care operators, who were provided with rapid, point-of-care antigen test kits starting in 2020.

Some test makers, such as Quidel, have found evidence that their devices do detect the omicron variant. Abbott's BinaxNow system detects omicron in live samples "at equivalent sensitivity as other variants," the company said in a statement last week.

Laboratory data do not replace clinical studies using patient samples with live virus, the FDA cautioned regarding its own new findings. Clinical studies are ongoing, it said.

Feds Press Pause on LTC Monoclonal Antibody Mainstays, Approve Two COVID-19 Pills

The omicron variant has created a shifting landscape of COVID-19 treatment and prevention possibilities for long-term care clinicians, with major changes occurring over the winter holidays.

Among the breaking clinical news developments in December:

Feds halt allocation of REGEN-COV, other key monoclonal antibody treatments: Federal officials have halted further allocation of certain monoclonal antibody drugs that have been key to long-term care clinicians' COVID-19 treatment protocol for vulnerable residents. Distribution of the bamlanivimab and etesevimab together, etesevimab alone, and REGEN-COV have been put on pause, the Assistant Secretary for Preparedness and Response (ASPR) and the Food and Drug Administration announced on Dec. 23. New COVID-19 variants are able to resist the drugs, according to their makers. Officials are awaiting updated data from the CDC before deciding on next steps, ASPR said.

In the meantime, federal authorities are scrambling to provide the one monoclonal antibody treatment recently shown to work against omicron. There are 55,000 doses of sotrovimab (brand name Xevudy) currently being allocated, and an additional 300,000 doses of the drug will be available for distribution in January, ASPR said.

Two COVID-19 pills authorized for emergency use: In a pandemic first, the FDA has authorized two oral drugs to be prescribed to adults and children who have mild-to-moderate COVID-19 and are at high risk for progression to severe illness, including hospitalization or death.

Pfizer's Paxlovid (nirmatrelvir tablets and ritonavir tablets, co-packaged), was authorized on Dec. 22. It is the preferred clinical choice by federal health officials, having been shown to reduce hospitalization risk by up to 90% in clinical trials. Merck's molnupiravir, authorized for use on Dec. 23, is about 30% effective against hospitalization risk in comparison. It should only be used in cases where alternative authorized COVID-19 treatment options are "not accessible or clinically appropriate," according to the FDA.

Each drug should be initiated “as soon as possible after diagnosis of COVID-19 and within five days of symptom onset,” the FDA said. Supply appears to be tight and varies from state to state, according to one recent report.

J&J booster cuts healthcare worker hospitalizations in South Africa, researchers say: Research in South Africa shows that the Johnson & Johnson COVID-19 vaccine booster may be effective against the omicron variant. A study of 69,000 healthcare workers during the rise of omicron in that country showed that workers vaccinated with two doses of the vaccine were 85% less likely to be hospitalized when compared to their peers who had received only one dose, according to a National Public Radio report.

On Dec. 17, the Centers for Disease Control and Prevention endorsed a recommendation that Americans preferably be vaccinated with the Pfizer-BioNTech or Moderna COVID-19 vaccines over Johnson & Johnson’s shot. The CDC’s decision hinged in part on the risk of blood clots seen with the J&J vaccine, and the relatively high level of protection against COVID-19 afforded by the other two options.

Omicron hospitalizations about one-third that of delta; South Africa’s 4th virus wave peaks: More signs that omicron may be less deadly than previous SARS-CoV-2 variants have arisen. Despite the fact that omicron appears to be more transmissible than its delta cousin, it is linked to about one-third less risk of hospitalization, according to researchers in the United Kingdom. Meanwhile, a fourth wave of infections caused by the variant in South Africa, where omicron was first discovered, appears to have peaked, authorities said on Thursday, Dec. 30.

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