Hospice in Long-Term Care in the Year of the Virus
Presented by the Oregon Office of Rural Health Annual Forum on Aging
Presenters: Dr. Michael Knower and Lee Garber
May 27, 2020

Rosalee Locklear: All right. Good afternoon and thank you all for being here. We are going to go ahead and get started. I want to thank you all for being here today. I'm Rose Locklear. I am a Program Manager at the Oregon Office of Rural Health. This year, we were unable to have a live Forum in-person to see all of your faces. However, we are taking some of the sessions and offering them virtually, as webinars, and this is one of those presentations.

So before we get started, I want to take a moment to thank our partners who have stuck by our side through the whole coronavirus pandemic. That is going to be our Central Oregon Health Council, PacificSource, St. Charles Health System, Samaritan Health System, O4AD, Oregon DHS, PeaceHealth, GOBHI and Columbia Memorial Hospital.

A few housekeeping tips and tricks before we get started. Audio and video for participants is muted to keep the background to a dull roar. If you would like to ask a question, please use the chat function, and I will read your questions to the speakers at the end of the session. Presentation slides are going to be available at the link here on this slide, Oregon Office of Rural Health's Annual Forum on Aging under webinars, and this recording will have closed captions included with it.

So, without further ado here, we are going to present to you all today, "Hospice in Long-Term Care in the Year of the Virus", by Dr. Michael Knower and Lee Garber. Dr. Knower is from St. Charles and Lee Garber is from Regency Rehabilitation and Nursing Center of Prineville.

Dr. Michael Knower: Thanks, Rose. As Rose mentioned, we were really hoping to being able to have a Forum on Aging in Rural Oregon, but this single strand RNA virus disrupted our plans to say the least. So today, Lee and I have revised our originally intended topic, and we want to talk about some of the impacts that coronavirus has had on our folks, and for those of you who work with the chronically ill, terminally ill, elderly, I don't need to tell you, these are the most compromised folks out there, and so we hope that our short presentation and the following presentation will spark some ideas for how we can continue improving what we do for the folks in the rural communities.

Disclaimer: Please note that the opinions you are about to hear expressed are those of your presenters and do not necessarily represent the views or policies of St. Charles Health System or Regency Pacific management. Most of you have been following the number of COVID-19 cases in Oregon in the last two months. You need to get your life and get yourself together and check out something more interesting, but, as of last night, this is what the numbers look like.

Now, most of us have a vested interest. We would like to see the numbers in our communities at a flat zero, but, that is not the case. You are aware Oregon has been imperatively spared the kind of onslaught that has hit places like New York and Michigan. Deschutes County with 0.62 cases per thousand, population is low, compared to places like Multnomah County with 1.30 cases per thousand or Marion County with 2.64 cases per thousand. Yeah, we're at zero, but we are low compared to some other places. Now, looking at Jefferson County, they're coming in at 1.0 cases per thousand so they are ranking right between Malheur and Morrow counties just above the state average.

Here in Crook County, up until this last weekend, we had been sitting at a single case for over a month, and then we had, for us, a comparatively substantial explosion as a result of someone traveling from the west side of the Cascades into our county. Those who have been tracking the numbers are also aware the risk groups for both infection and fatality as a result of COVID-19 are those over 60 and those with chronic medical problems, those who look like Lee's residents or our hospice patients.

First significant outbreak in the United States occurred in a nursing home in Kirkland, Washington, and as of the most recent OHA COVID-19 weekly report there are 7 facilities in Oregon which have had outbreaks of more than 10 cases, and facilities currently account for about 10 percent of all cases and about 40 percent of all deaths. To date, neither Lee nor I have had any COVID cases in our respective populations.

Lee Garber: To carry on with what Dr. Knower has discussed, even though we have had basically minimal exposure to COVID-19 in our community, and none in our facility fortunately, we were still confronted with the reality of dealing with a new virus. We still had to deal with the winter flu season virus.

I do want to say that the COVID-19 virus did impact our census. And as of this time, we show an 18 percent decrease. Couple reasons come directly to my mind for the impact on our census. Number 1 and foremost is the lock down in the hospitals for elective surgeries and procedures. As most of you know, or may know, our primary referral source is from the St. Charles Hospital System, and so when that goes down, we go down.

The second is due to the regulation of restricting visitations, including family members, there has been families that chose to take their loved ones home so they could continue to interact with them rather than place them in our nursing facility where their visitation would be restricted. Finally, I want to mention that as Dr. Knower alluded to, the outbreak started out in Kirkland, Washington in a nursing home. I definitely feel that there is a fear factor in admitting to a nursing facility, at least at that time, and maybe even now because of the possibility of admitting to a nursing facility would cause a demise of their loved ones. At this point, I do want to note Regency Prineville has had no COVID-19 cases, and I knock on wood as I say that.

Dr. Michael Knower: Now, on the other hand, as Lee's census was going down within 10 days of Governor Brown's emergency declaration, St. Charles Hospice's average daily census increased

by 15 percent, and it has stayed at that higher level. The other thing I've noticed is that many folks that have been coming on to our service have been in duress, they have had uncontrolled symptoms, prognosis of hours and days, and these people have jacked up our acuity and intensity.

Most of our hospice patients have been living in their own homes and doing fairly well until shortly before they were admitted to hospice, their escalating symptoms translate into more frequent, more protracted, more intense visits from our staff. Needless to say, we were unable to abruptly increase our staffing by 15 percent over the course of 10 days. This is not the only time that we are going to be talking about staffing during the presentation.

On the other hand, our skilled nursing facility patients have generally been significantly compromised for quite a while. In many ways a nursing home resident who qualifies for hospice admission on the one hand is probably one of the sickest people you can imagine, but, things tend to unravel more slowly, more predictably, you can anticipate their decline, and you can plan accordingly. So suddenly, our nursing home patients with surge in completely decompensating patients became the stable folks on our service.

Now, required hospice services are specified under the Social Security Act and are regulated by the Centers for Medicare and Medicaid services within the U.S. Department of Health and Human Services. Hospice professionals have certain care and documentation requirements with fairly tightly specified deadlines and frequencies to periodically ascertain whether or not or patients are indeed terminally ill, we need to revise and update the care plan more frequently to make sure the care plan is consistent with the patient's condition and in line with each patient's goals.

So if our access to our patients is restricted or disrupted, we are off on some of these deadlines. Additionally a certain proportion of our total hours are required to be provided by volunteers. A pandemic afoot, we cannot reasonably put our volunteers at risk for a communicable disease, so how do we meet the requirements of these regulations?

Lee Garber: In particular to our situation, just when you get adjusted to the latest regulations, the regulations change. Establishment of a single point of entry to get into the facility was pretty easy, but the process of who to screen, how to screen, and what to screen kept changing. I think our screening tool changed about four to five times since this began.

We've always had a process where we quarantined for things like flu or norovirus, but this new coronavirus was a new ball game, and it required a high demand on PPE's. And so stocking up on PPE's was a new challenge that we faced. I'll warn you here, you'll hear a lot about PPE's throughout this presentation. But the challenge I think affected me personally the most was the restriction of visitation. This is one of the most more difficult in terms of emotional support, not only for the family, but to the residents. This challenge required that we change our approaches and the ability to have families see and talk with their loved ones, through a variety of mechanisms.

One of the ways we decided to deal with this is making a point person. We delegated our social service director to communicate with families and responsible parties regarding the change in conditions. Given the nationwide demand on PPE's, the facilities in our corporate network pooled our resources together to make sure no one facility would run out. We had weekly inventories to assess supplies and to send that up to the corporate network so they could determine who had what supplies and who needed what supplies. And of course, we held numerous meetings and did lots of individual and shift coaching.

Dr. Michael Knower: Fortunately for us the Social Security Act is so huge, so complex, and cumbersome that the rules stay fairly fixed. Now, as the CARES Act as been implemented and as CMS has been sorting this out, we think that they are permitting virtual visits for recertification, at least for the time being. The plan of care review strictly speaking doesn't require in-person visits, but our feeling has always been that this is best practice as we do this on a every other week basis.

Now, in our case, Regency Prineville understands the importance of hands-on, eyes-on assessment, and they have continued to allow our nurse case managers into the building.
As far as the volunteer hours are concerned, CMS had to put those on hold for the time. So far, as a lot of the other regulations, they have told us that they are going to cut us some audit slack, at least for the time being. I doubt that any of us in rural areas suffer from having too much staff. We have limited staffing, hospices with most patients residing in private homes, we also cover lots of ground.

So given the 15 percent increase in our census, our nurses, social workers, chaplains and aides have been spread even thinner than they were three months ago. Long-term care facilities have made sense to collaborate with facility staff, if the staff knows what our hospice needs to comply with CMS regs. They can have access to much of the information in the course of providing care to their residents. And likewise, our hospice staff, when they do go into the building may be able to pick up some of the tasks in the coordination we may need to meet the regs.

Lee Garber: As maybe most of you know, we are required to report to the state agencies, and to some of our regional offices. When our residents have tested for infectious disease, and the outcome of those tests, if you are involved in long-term care, you probably have similar requirements. One of the things you need to have is an organized reporting structure and be able to delegate and designate reporters. As well as keeping meticulous records so that we know what you have reported and can refer back to those as needed.

Hospice, I believe, has a different reporting structure. It cannot help long-term care with reporting, but knowing they are expected to increase visits in the final days of life may take some burden off of your staff, especially nurses and nurse's aides. Make sure you and your local hospice have process for communicating resident status and hospice visit frequencies.

Dr. Michael Knower: This is probably a wasted question and fortunately with you all muted, I don't have to listen to your answers, but has anybody's inbox suffered from a drought since the start of COVID-19? I thought so. On the hospice side, most of the regulatory noise comes from CMS in Washington, D.C. The CDC also has a few guidelines regarding infection control for home-health and hospice. We also have, and you probably also have, corporate policies and procedures. With the COVID-19 pandemic, infection control policies are being reviewed, updated and disseminated. Travel and education processes and policies are being reviewed and updated. Policies on hours, working locations, documentation, reporting are all being reviewed, updated or sometimes being written for the very first time.

Usually good for at least one e-mail a day, we get updates from our corporate office. In addition, our professional organizations all have their own recommendations, how to be handling things and how we should be attending to our own self-care.

Lee Garber: To continue on that, the nursing facility also faced that major challenge. We were confronted with enormous e-mails, directives, coming from a variety of sources, with the same message. The challenge being to filter through all that inbox messaging to determine what to pass on and how to do that. I want to stress it is important to designate one person and an alternate to be keeping an eye on the inbox, to have that person summarize the information and communicate that to the staff, those that need that information.

You don't want to get things missed in this type of environment, and you don't want people assuming things that have not been clarified. And you don't want your staff to go through spending hours sifting through the e-mails to get that information. In my case, I took the task on myself, but that doesn't mean you cannot delegate someone else to do that.

Dr. Michael Knower: Now, on our side, our hospital system set a daily incident command meeting when COVID was first threatening to hit Oregon, and before the governor's declaration. Because our hospice patients are not generally in one of the hospitals, there was the possibility that home health and hospice might be overlooked, and we made sure that that did not happen. Our director was one of the folks sitting at the table, and she took it upon herself to give us daily updates during our morning staff huddles, and each afternoon the incident command team would send out its own e-mail.

So here are some general suggestions for dealing with the static. There is no one size fits all approach. You know your organization. You know the people you work with, and as Lee said, please don't do things the way that we do it just because that's the way we do it. Lee called his own number as far as being the e-mail point person. If you're a long-term care facility director, please feel free to delegate and just because we have a morning huddle at our hospice, please, please, please don't go starting one just because that's what we do.

Give your email point person the authority to hit delete. As Lee said, a lot of this stuff is redundant, and you don't want to be reading the same thing six times a day. You need to figure

out how to sort through the static, pull out what really matters, eliminate the redundant and communicate an effective summary to your staff.

Lee Garber: At Regency Prineville, it is our primary goal to give our residents and patients the best care we can give them. None of us wants to be sloppy with our approach and put people at unnecessary risk. Our staff is accustomed and trained to monitor for influenza each winter, but now we have to monitor another virus as well. We need to be aware of what our patients and residents might be exposed to, where they might be exposed, and to do our best to minimize that exposure.

Dr. Michael Knower: Prior to COVID-19, our volunteers used to deliver medications, deliver flowers, stop in, cheer up patients and their families. As I mentioned before, most of these activities came to a screeching halt with COVID-19. Specifically relating to this presentation, we are no longer, at least for the time being, sending our volunteers into facilities.

We now have our professional staff delivering medications, on their scheduled visits, and the cheerful bouquets are probably not going to be coming back for a while. We previously assigned patients to social workers, nurses aides based on patient's location and each caseload. We now have another factor to consider that we are trying to make sure that there is only one team, nurse, social worker, aide, chaplain, going into each specific facility.

We wanted to help the facility limit the amount of traffic in and out of their buildings while introducing another wrinkle in assigning patients. Always carry hand sanitizer. Masking, gloving, hand sanitizer help us to be able to be compliant with CMS and DHS regs. We are going to be talking more about masking when we get to slide 22.

Lee Garber: With all the regulations and things that came with the advent of COVID-19, all new admissions were required to be tested for SARS COV-2. Rather than making our staff make a choice who gets tested for which virus, if a resident was being tested for regulatory or symptomatic reasons, we tested for both. Our isolation requirements for residents coming into the building or returning to the building, were already in place. To reduce the exposure risks of non-residents coming to the building, we restricted visitors. By the way, that was also mandated, so it was for a good reason.

Dr. Michael Knower: One of the biggest benefits for me in assembling this presentation was to gain a better understanding of Lee's regulatory and operating environment. My organization has policies on infection control, his organization has policies on infection control, and COVID-19 has given us incentive to review and update these policies. Perhaps we could borrow things we like from one another's policy, if our corporate figures approve rather than reinventing the wheel.

Please don't wait for another pandemic before you review your policies. One of the advantages of living and working in a smaller community is the opportunity to actually know the people who are the voice on the other end of the call or fingers that just generated that tweet, text or e-mail. This may be especially important in the setting of a pandemic when things are changing rapidly,

when you and your agency are not the only ones impacted. I know where Lee's office is. Lee has my cell phone number, I have his cell phone number. I am not going to give out Lee's cell phone number at the end of this presentation, but, I would encourage you to make similar connections in your community if you have not already done so.
When we step into Lee's facility we can anticipate a clean environment, pleasant helpful staff who are caring for your patients. We don't have to worry about that friendly pit bull running loose or the hoarded newspapers stacked to the ceiling or encountering feces spread over most horizontal and vertical surfaces. Not many of our patients' homes are like that description, but we have seen a few over the years.

As previously mentioned, most of us recognized as SARS COVID was on its way across the Pacific ocean that PPE was going to be tight. If your office is totally unattached and freestanding, you get to call your own shots, write your own rules and order your own supplies. Let's be honest about it, most health care system infection control strategies focus on care in facilities owned, operated and maintained by the health system. It may have been a while since policies have been reviewed.

If your hospice or your facility is part of a larger system, your PPE will probably pass-through a centralized supply in a larger facility, in a larger community and through someone who really doesn't know what you do or what you need.

Lee Garber: Dr. Knower, it is always good to hear that Regency Prineville presents the kind of environment you'd like, and we would all like to have, your St. Charles hospice patients living in. One big challenge since the governor declared a state of emergency back in March has been keeping up and keeping enough PPE on hand. As I mentioned back in slide 9, the Regency Pacific system decided a couple months ago to begin tracking usage and inventorying, pooling resources, and allocating supplies where they were needed.

Dr. Michael Knower: Even under normal circumstances, we cannot afford to have staff members out sick, so keeping our staff healthy has been even more important in view of the increased census and increased acuity. St. Charles issued its first guidance on in-home visits Monday, March 2nd, six days before the governor declared a state of emergency and nine days before the first COVID case in Central Oregon. We were encouraged to consider whether virtual visit, in-person visit, and if an in-person visit was in order, our staff calling ahead asking if staff or anybody else had a fever or shortness of breath.

If our patient is in a facility, a virtual visit is probably more feasible and facility staff are now screening at the bedside for the same things we screen for over-the-phone. Our offices are now set up to maintain physical distancing. I have been doing most of my work from home since early March, and St. Charles is still encouraging us to work from home as much as possible.
We've been holding virtual huddles, virtual weekly interdisciplinary team meetings, and have been since March.

Universal masking is a St. Charles policy. We're wearing cloth masks in the office, surgical loop masks during patient visits, and COVID-19 N95 masks when performing aerosol generating procedures with a patient, family member or caregiver has been documented or has suspected COVID-19. Protecting our patients is one of the reasons for masking in previsit screening, but for a small, rural agency that does not have enough staff, not knowing where coworkers have been in the course of a day, protecting our staff may be an even more important reason.

Lee Garber: Well, I said we're going to be talking about PPE a lot, and I think Dr. Knower just kind of alluded to the fact why and how frequently we use those PPE's. In the facility, every time a new resident comes in or resident goes out and comes back in and goes to the doctor's office and comes back in, they're subject to a 14 day quarantine, which means donning of full PPE.

And with that said, do I want to stress that the importance of establishing, updating and communicating your policies, including PPE policies. They're so easy to overlook and we have to constantly remind our staff that that is important. I also want to address the governor's reopening guidelines, and I'm going to quote her, quote, "large hospitals and health systems in the region must have a 30 day supply of PPE, and rural or small hospitals must have a 14 day supply," end quote.

Governor Brown is addressing hospital PPE supplies, but I think those of us, including hospice that are involved in rural health care, and those of us caring for the frail, compromised, chronically and terminally ill elderly, know that we are out at the end of the supply chain. My recommendation is that you have more than a two week supply on hand. We at Regency Pacific Prineville are shooting for a two month supply.

Dr. Michael Knower: Perhaps the most challenging part of the COVID-19 experience, as Lee alluded to earlier is giving families the assurance that even though their loved ones are approaching the end of life, they are comfortable and well cared for. They've read the news reports of outbreaks in nursing homes. They've seen the film clips of families in parking lots trying to communicate with mom or dad through a closed window, and they just know those hospice people are the buzzards of death. Those of us in the health care also know that bad news sometimes may be better than no news at all.

Lee Garber: I'm really pleased and happy that Regency Prineville and St. Charles hospice have adapted really well to the constraints put on us by this pandemic. We allow families direct access and have made the logistical adjustments to facilitate those visits without putting our other residents at risk. I think Dr. Knower alluded to some window visiting, there is video chats, cell phones, other forms that we are using to make that happen.

Dr. Michael Knower: And as I mentioned earlier, our chaplain, social workers and other staff are required to increase their visit frequencies during the final week of life. In addition, they're making phone calls to field questions and concerns, reminding families that their loved ones are receiving excellent care and assuring them that our staff and Lee's staff are coordinating care.

If you could make it up to Regency right now, phone calls that nobody likes, but hopefully we have let families know how patients are doing so that these things don't come as a complete surprise. Families need to be assured that the left hand knows what the right hand is doing. If you're a hospice leading off your phone call with I'm Hillary, I just saw your mom, or if the facility leading off with, I was just here to see your dad, can be huge.

Given none of us in rural communities suffer from surplus staff, making up a tag team arrangement between hospice and facility staff to alternate calls to the family can facilitate more frequent communication and spread the phone time workload around. Most of us in Oregon are now in Phase 1 of reopening, so is this discussion even pertinent anymore? Personal hunch, and that of many epidemiologists, is we will be getting hit again in six months or less. I hope I'm wrong, Lee hopes I'm wrong, but we should be prepared just in case.

Lee Garber: I think preparation is the key, whether it happens or not. And right now, we have the opportunity to sort of catch our breath, clear our heads, and regroup. We hope today's discussion has been useful and helpful to address some of the challenges that have come along, and will come along, and for helping us to prepare for the challenges that are yet to come.

Dr. Michael Knower: Remember, that we, St. Charles and Regency of Prineville began gearing up before Governor Brown declared state of emergency and before there were any cases in Central Oregon. Most of us in rural areas are accustomed to working without surplus staff and without huge inventories. Time is our most precious commodity and anticipation is our most effective tool.

Rose Locklear: All right. So if there are any questions from the audience, please type them into the chat box, and I will read them to our presenters. So I will give you a couple minutes to put your thoughts into words, and I will go ahead and get started with one question for you all. Dr. Knower, how are your protocols being developed now, and how will those impact what you, kind of left off saying, what do you think will most likely be a double wave of flu season?

Dr. Michael Knower: To refine your question a little bit more, Rose. In terms of protocols, St. Charles have been pretty proactive as I indicated, we -- inaudible -- infectious disease procedures. We did have a pandemic policy already in place, so now we actually have a pandemic and so we've looked at that to make sure that that's really up to speed. In terms of the things coming at us, going to keep an eye on CMS.

Rose Locklear: Great. Thank you so much. And Lee, you mentioned that you have assigned one person, which is yourself, to retrieve information and collect it, and then present it back to your team and that you do it in a staff huddle. If it weren't the director or medical director of an organization, who would you suggest would be a good fit for this role?

Lee Garber: Well, I think there is a number of people you can delegate to. For me, the second person would be the director of nursing services. She not only gets CCed on many of the e-mails, but beyond her I'd also look at the social service director. She is already in communication with

the families and responsible parties, and we do that weekly, so both of those, those are two point persons who can handle the position.

Rose Locklear: Lovely. Thank you.

Lee Garber: Okay.

Rose Locklear: Dr. Knower, you mentioned the hospice census rose as the long-term care censuses dropped. Do you know or have any hunch as to why that may be?

Dr. Michael Knower: I think Lee addressed why his census dropped with elective procedures being put on hold, and with the public perception that nursing homes were at increased risk. In terms of numbers, and this is totally personal perception, a lot of folks will postpone going on to hospice because, again, they just know that we are the buzzards of death and we hear people say, I'm not ready for hospice or I don't want to come on hospice. I want to fight this thing, but my sense is with COVID-19 hitting the United States, people started to realize that if I get this critter, I will probably die, and as a matter of fact, come to think of it, even if I don't die of this critter, I'm probably going to die anyway, and so it was a good reality wake-up call.

Rose Locklear: Thank you. So it sounds like, relatively speaking, you've had a pretty smooth sailing process out there in Prineville. For other organizations that may be just experiencing this situation or not having had such an easy experience, what, from each of you, Dr. Knower and Lee, what would be your greatest advice moving forward, especially as we progress in the next few months?

Dr. Michael Knower: My advice would be given that we don't have unlimited staffing, unlimited time, please don't reinvent the wheel. And you put our contact information up there, and even though my in-basket and Lee's in-basket are not starving for want of communication, if we can help you out with some of our ideas, please don't hesitate to contact us. The other thing that I think is probably going to be the biggest benefit of this event is its conversation, people can exchange ideas and we can help one another through the whole process.

Lee Garber: Well, my thoughts are this: I think we have the advantage of experience in terms of we've gone through this, at least we're going through it, and like Dr. Knower said, we have already set up a number of things to deal with the challenges that come. Now, I know different settings, you know, not exactly like ours, but I think the principle basics will be the same everywhere, that's preparation of having PPE's if your environment or situation will involve that, and to communicate with others that are in similar situations to see what they're doing and be ahead of that on the curve so that you're not waiting and wondering, well, what happened? You've got to be on the forefront knowing what happened and what other facilities have experienced and use their experience.

Rose Locklear: Great. Thank you. So both of you mentioned a great deal pertaining to regulations and are there any regulations that need to change in your opinion in light of COVID-19? And

have there been regulatory changes that have been helpful and that should be kept after the pandemic is over?

Dr. Michael Knower: The topic that Lee and I were originally going to present was called, What I Wish Every Clinician Knew, we were going to talk about the regulations in depth. We don't have time to get into that specifically right now, but I know in our situation, especially with regard to the virtual face-to-face recertification visits still being worked out, so, again, as Lee just said, communicate, communicate, and Lee and I both try to stay on top of the regs., so if you're in long-term care, send your emails to Lee. If you're in hospice, send your emails, if you know somebody who is even better versed in the regulations, don't hesitate to get ahold of them, because things are changing literally every day.

Lee Garber: I want to say that I can't think of a regulation that's been placed on long-term care that I can actually say is not necessary. I think one of the regulations that causes me the most pain in terms of emotion to our residents and their families is the visitation rule. I wish we could find a way where we could make that happen on a more frequent basis, and yet, keep it safe for everyone. But other than that, I don't have any strong recommendations.

Rose Locklear: Beautiful. Well, thank you Dr. Knower and Lee for joining us today and sharing about your experiences with COVID-19 and hospice and long-term care out in Prineville. We're at the top of the hour, so I want to thank everybody for being here today and we will catch you next time. Thanks so much.
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