Ruth Adewuya, M...: Hello, you're listening to Stanford Medcast, Stanford CME's podcast where we bring you insights from the world's leading physicians and scientists. If you're new here, consider subscribing to listen to more free episodes coming your way. I am your host, Dr. Ruth Adewuya.This episode is part of the COVID-19 miniseries, and today we are reflecting on COVID-19 management in nursing homes. I am joined by Dr. Marina Martin and Jennifer Wieckowski.

Dr. Marina Martin is a clinical associate professor of primary care and population health medicine at Stanford University. In 2012, she joined the geriatric medicine faculty at Stanford as a primary care physician in the newly-formed Stanford Senior Care Clinic. In 2014, she became the medical director of the clinic, and in 2015 became the first section chief of geriatric medicine in the School of Medicine. In this role, she oversees clinical, educational, and health services research programs that promote optimal, compassionate, personalized care of older adults, especially those with frailty, dementia, or very advanced age. Dr. Martin's clinical practice currently consists of post-acute rehabilitation and long-term care at Webster House Health Center.

Jennifer Wieckowski is a senior executive director at Health Services Advisory Group, which is California's Medicare quality innovation network quality improvement organization. With more than 17 years of experience working in healthcare quality improvement with community providers including hospitals, nursing homes, home health agencies, and community based organizations, she is responsible for providing oversight and direction to the tasks associated with the QIN-QIO 12th scope of work contract with CMS to improve the effectiveness, efficiency, and quality of services delivered to Medicare beneficiaries.

Nursing homes have played a central role in the COVID-19 outbreaks in the United States, a fact first recognized after an outbreak in a nursing home in Kirkland, Washington, which resulted in several deaths. Since then, further outbreaks have underscored the enormous risk of COVID-19 in the older nursing home population. COVID-19 disproportionately affects nursing home populations due to the high proportion of frail older adults and those with underlying chronic conditions. So today, I'm pleased to have two experts on this topic joining me in the podcast. Thank you both for being here.

Marina Martin, ...: Thank you for the invitation.

Jennifer Wiecko...: Thank you.

Ruth Adewuya, M...: So let's get started, Dr. Martin, and look back to March 2020, which seems so long ago. When did you first become concerned about coronavirus in nursing homes that you practice in?

Marina Martin, ...: There was so much uncertainty at the beginning of this pandemic. We weren't sure if this event in Washington was a fluke or if this was going to be a pattern.

And we were still learning so much, even the basics, about this virus and how it was transmitted. We didn't have a test for it. We didn't even know for sure at that time that older adults seemed to be far more vulnerable and more likely to die. So as these pieces of the puzzle started to fit together, I think we all very quickly realized that congregate living settings for older adults were going to be the very worst possible setup for getting coronavirus and for this disease spreading. In fact, we had an assisted living that we work with that had six unexplained deaths from pneumonia before we even had a test or even knew that coronavirus was in our area, that in retrospect probably were early coronavirus cases.

There was so little knowledge at the beginning, and every case of somebody who got symptoms like coronavirus caused great worry. And there was panic, but people kept going to work, but there was this feeling of dread or the unknown at that time, that eventually it settled into knowing how serious this was for us. But at the very beginning, it was a lot of just, we don't know what to do or how to react to anything. It was really scary at the beginning.

Ruth Adewuya, M...: Facing an unknown versus now knowing the reality, I don't know which is worse.

Marina Martin, ...: Yeah, they're both challenging in many ways. Different sets of challenges, I'd say.

Ruth Adewuya, M...: Yeah.

Marina Martin, ...: So at that time it was like each day would bring something new and you didn't know who to call, but it was good to see people reaching out to each other from the very beginning for support, questions, information, what are you doing? Can you help with this? That happened right off the bat.

Ruth Adewuya, M...: Before we continue, I think it's great to take a step back with definitions. We're talking about nursing homes. I also want to recognize that there are other forms of long-term care, assisted living, other residential facilities. Can you talk about some of those types and the differences between them?

Marina Martin, ...: What we think of often as a nursing home is also called a skilled nursing facility or sometimes a long-term care facility, and those are usually places that serve two important purposes. One is they are a home or a permanent residence for people who really need a lot of assistance with basic activities of life, like bathing or dressing because, of medical issues that they have. The other major thing that they do is help people get back on their feet after a hospital stay if they've been really sick or had a big surgery and can't do much, they also have a rehabilitation service. So these are medical facilities that are regulated by the Department of Public Health that do both of those important jobs. And they tend to have a lot of older and very ill residents or people who are very weakened or de-conditioned by having gone through a serious illness.

Assisted living is actually a form of housing that often older adults, but sometimes younger adults with disabilities, might live in that kind of setting. It's not a medical facility. It's a home, and sometimes a bigger home, a bigger building that has caregivers that help with things like the bathing and dressing and all of that, but it doesn't have doctors. It often doesn't have much for licensed nursing, if any. So they're really a nonmedical facility and they're not stocked with things like PPE normally, and they haven't been trained to handle outbreaks. And they're not regulated by public health, they're regulated by social services. They especially were not ready to face this kind of pandemic.

Both of those settings are equally vulnerable, I'd say. The residents are very similar. The staff are very similar in many ways. But the assisted living kind of set up really wasn't ready medically to handle this. Nobody was, actually, but at least nursing homes had some PPE and some previous experience managing flu outbreaks and things like that that they'd been trained to do. Nursing homes also have the folks coming from the hospitals, so they have new people coming in and out, which is not necessarily as true in assisted living. So in a way they're even more vulnerable because new admissions could bring in the virus.

Ruth Adewuya, M...: Jennifer, I'm curious to hear from you, with your perspective and your expertise, why do you think the coronavirus was and is such a serious problem in nursing homes?

Jennifer Wiecko...: Back in March 2020, when we learned about the Life Center of Kirkland in Washington, I specifically remember it was March 7th and I received a call from my colleague, Dr. Mike Wasserman from the California Association of Longterm Care Medicine. And he just sounded the alarm and SOS. We scheduled a webinar that CALTCM run on March 9th. He blasted it out statewide because we knew that with the experience from Kirkland, that our nursing homes were in a very vulnerable spot. I'd like to think we prevented the spread by sounding the alarm so quickly, but it became, and still is, a serious problem in nursing homes.

And I think the reasons why... One is what Dr. Martin touched on, is the type of facility. Nursing homes are communal in nature. But I also think the staff were not prepared. We didn't have enough PPE, personal protective equipment. It was used improperly. We didn't have that training. When we had a shortage there was the crisis capacity strategies where we had to extend the use of PPE, the N95s. The extended use and reuse, which if not done correctly, can cause contamination. So it just really put our long-term care population at high risk.

And I think another reason, which is better now, is testing. When it first started, we didn't have the tools to rapidly test individuals and identify if they're COVID positive. And I think that's really hard with this virus. Something like 30% of people never develop symptoms. Staff, asymptomatic, coming to work. They have no idea they're carrying the virus and unknowingly infect others. But now we're really sharp on that. More testing, especially for those who are unvaccinated. So that's closing the gap a little bit, but it's still a tough issue.

Ruth Adewuya, M...: Dr. Martin, fast forward to now, how are older people being cared for if they are symptomatic for coronavirus?

Marina Martin, ...: We're in another evolving time now as we have a new variant, so we can much more quickly determine if somebody has coronavirus. There were times early in the pandemic when it would take a week or more for us to get the results back. In the meanwhile, the virus could spread like wildfire through a building. So now we can determine that much more quickly and isolate. We're set up to do an immediate then widespread, full testing of everybody, staff and residents of the facility right away. So that helps a lot for controlling spread.

We have the PPE on site and we have much more familiarity with how to use it. So all of that is really good news. We have some better knowledge about how to treat somebody with coronavirus and support them. We don't have a curative medicine necessarily, but we do have some things that were clinically proven to be beneficial. And a lot more people around us that we can reach out to to ask, how do I manage this? Everybody's much better informed.

Ruth Adewuya, M...: What about healthcare access for conditions other than COVID-19? How are they affected?

Marina Martin, ...: I think there's more comfort now with accessing healthcare for other conditions sometimes because they actually were left too long and the person really needs care for a condition now that it was delayed during the height of COVID outbreaks before vaccinations. I think people feel more comfortable again going to the emergency department now, or going out to get a test like a scan. So there is some catching up being done, at least at this point. Hopefully there won't be large surges. I think whenever there's a large surge, people really feel like pulling up that avoiding some of that. I think there's more trust that you can safely encounter healthcare because we know after doing this now for quite a while that the transmission in a healthcare setting is pretty minimal due to all the protocols they put in place.

Ruth Adewuya, M...: Jennifer, so certainly the CDC has released some guidance and recommendations, but it seems like each state is really responsible for the mandates and what facilities have to do. Is there a role for the federal government? What's the role of CMS? The Department of Public Health? There's a lot there that I'm throwing at you, but what are your insights on that?

Jennifer Wiecko...: There is a lot of guidance, that's for sure. Our nursing on driving to sift through that and understand it, absorb it, and then implement it. The two main agencies that nursing homes are looking to for the distribution of guidance, the nationwide would be CMS, which is Centers for Medicare and Medicaid Services. And the other is CDC, Centers for Disease Control. Ultimately it's up to the state to decide if they're going to implement more restrictive guidelines. The stricter guidance supersedes the less restrictive guidance.

In California, as an example, our nursing homes looked for guidance from the California Department of Public Health, or CDPH. They've had more guidance in 2020 and 2021 than ever before. And it comes out in the form of what's called AFL's, or all facilities letters. And more recently the governor of California is distributing state public health office orders. We have 61 separate public health departments in California that oversee the 58 counties. Those local public health departments do have the right to supersede the California Department of Public Health statewide guidance with their own guidance based on what they know, what they think is best for their county. For example, Los Angeles county, they have more stringent visitation, testing and cohorting guidance. Sometimes they parallel with what the state's saying, sometimes they say, nope, we're going to go stricter.

Ruth Adewuya, M...: Dr. Martin, as some of these policies and protocols were implemented to reduce the spread of COVID-19 in nursing homes, how were the perspectives of residents and family members considered in balancing infection control with quality of life?

Jennifer Wiecko...: I wish I could say that they were extensively incorporated. At the beginning, they clearly were not in the setting of really not knowing much about the virus. And even once we did know a little bit more, there was a very, very strong sense that we needed to completely lock down these facilities because of the degree of risk, to protect both the residents and the staff, as well as visitors, frankly. Looking back, I understand, especially at the beginning, was probably the appropriate thing to do because we just didn't know enough. Yet the price has been way too great and was way too serious and severe for many residents and their families.

The isolation, the separation of people who've been married for 70 years and were regular visitors and siblings and adult children from their loved ones who are vulnerable and may or may not remember what's going on or understand the pandemic, there's just a lot of sadness around that lost time and the pain of that separation that I think, looking back on it, we probably could have stopped sooner. There was a lot of advocacy on the part of physicians groups, groups like HSAG, families rights groups, et cetera, to say we need access to our loved ones. They may be surviving COVID, but they're dying of loneliness.

Fortunately, that was eventually heeded and things were opened up more. And now I think we're at a much more balanced place. Once vaccinations came in and nursing home residents were some of the first to get vaccinated. And there was pretty high uptake among residents of nursing homes, the patients themselves. That kind of changed the equation very quickly and let us look at reopening. I wish we'd had more input from families and residents early on. These are many times residents who can't advocate all that well for themselves either because they may have some cognitive impairments or just be too sick. It's not a group that can easily speak up.

Ruth Adewuya, M...: Outbreaks in the nursing homes have brought these facilities to the forefront of this national conversation. There have been investigations with infection control, but it's also led to broader discussions about regulation, financing, family decision-making and staffing. How do you think this national focus will affect the structure and care delivered in nursing homes after the pandemic?

Marina Martin, ...: California is now requiring that every nursing home has a full time infection preventionist, or IP, as of January 1st, 2021, you can check out assembly bill 2644. We realized the importance of surveillance and proper hand-washing and PPE and testing and everything that you need for a solid infection prevention program. We've achieved significant infrastructure improvements in that area. So many lessons learned nationwide, but there is a fear that we don't want to get back to some of our old ways pre pandemic. Having a full-time IP is a solution to continue, somebody's job to prevent future outbreaks, not just COVID, but also the flu or MDROs or HAIs like C difficile, VRE, MRSA, CLABSI, pneumonia, and CAUTIs.

Ruth Adewuya, M...: Jennifer, who is an IP? Is this a nurse, a physician? What is the makeup of an IP?

Jennifer Wiecko...: In California, they are requiring a nurse. Our state is offering training for IPs. California Department of Public Health has a program. CDC has a program that they have to go through.

Ruth Adewuya, M...: Dr. Martin, any thoughts around this national conversation and its impact on nursing homes?

Marina Martin, ...: My hope is that we now have a better sense within the medical community of the important role that nursing homes play. Previously I feel like they were like these islands in the healthcare system out there on their own. And even though a large proportion of patients discharged from the hospital go to a skilled nursing facility for rehabilitation, nobody has ever really been in one. We don't train our doctors. They spend all their training in clinics and in hospitals. They don't spend any time in skilled nursing facilities training. So we're not really aware of what was going on out there and how important these places are and some of the unique challenges they face. I think there might, I hope, be more awareness that they're really an integral partner in this whole healthcare system.

Ruth Adewuya, M...: You mentioned that clinicians don't even train in skilled nursing home facilities. I'm just curious about your story and how you got into this field.

Marina Martin, ...: That's a great question because I had a very brief exposure as an internal medicine resident, as an intern, like one half day I think in a skilled nursing facility during my geriatrics rotation. Then I really didn't go back until my fellowship training in geriatric medicine, which is the one field of medicine where you do spend a significant amount of time caring for patients in a skilled nursing facility. So that was my real introduction. But even then, I had never

thought of it as a place where I would be practicing clinically when I finished all my training. And I went first into geriatric primary care for older adults. I was working in a clinic, which was familiar and comfortable.

And we had some changes in our faculty. We had a lot of faculty who wanted to work in our primary care clinic and we had somebody retire in our skilled nursing facility so we needed someone there and I was like, "Okay, I'll switch." I'm so glad I did. I really enjoy the rehabilitation part and getting to take care of people who've come out of the hospital and really understand hospital medicine and practice almost kind of hospital medicine with them. And then see them get better, which sometimes you don't get to do in the hospital because they still leave pretty sick. Then also basically really long-term primary care where you really get to know the patients and take care of them for the rest of their life. You do both things in one setting. So it's been a really great place to practice. That's not known by a lot of people in medicine.

Ruth Adewuya, M...: Yeah. Thank you for sharing the story because it sounds like you fell into it.

Marina Martin, ...: I fell into it.

Ruth Adewuya, M...: That's fantastic. Continuing our conversation around nursing home staff, Jennifer, you had mentioned this mandate within California to have an IP in all of the nursing homes starting January, 2021. But then I think I want to layer that with the knowledge that nursing home staff typically have low pay. That probably contributes to not only recruitment, but also retention. One in six nursing home staff usually works at least an additional job. Because of the stress of the pandemic, there's not a lot of retention. Dr. Martin, what do you think are some steps that can be taken to improve conditions and pay for these essential workers?

Marina Martin, ...: I'm not an expert on the healthcare financing system, but I get the feeling that it's kind of broken in many ways, but one of them being really underpaying certain critical people in our healthcare system and possibly overpaying others or the money's going somewhere where it possibly isn't really going to make an impact. Whereas people who make a daily impact on patient care are not getting paid well enough and specifically certified nursing assistants, who both in the hospital and in skilled nursing facilities help the patient to get out of bed and use the bathroom, bathe, dress, all of those important things that if we were sick, we would really want a good one who's well paid and rewarded for their work.

But in reality, they're not. They're paid very minimal amounts, minimum wage often, and have to work multiple jobs. In a pandemic, that's a perfect setup for spreading an infection between nursing facilities. And the staffing ratios are really poor as well in skilled nursing facilities. So often there's 20 or more patients per nurse. In the hospital it's four patients per nurse or two or even one in the ICUs.

Ruth Adewuya, M...: Our hope is that maybe some silver lining from the national coverage from the pandemic will result in changes. In addition to pay, there's also the issue of education and training to meet these rapidly changing guidelines and the needs within the nursing home. Can you tell our listeners about some of the initiatives that have been available to nursing home staff?

Jennifer Wiecko...: I think that's another silver lining for the pandemic that stakeholders associations, Stanford, HSAG, we came together in this industry during the pandemic to offer education just-in-time. Information avenues where providers can learn, discuss their challenges, and in some cases, vent, cry, ask for help, you name it. They have similar experiences across the board so it's good for validation.

One thing we've done in our state is our Department of Public Health and our company, HSAG, and two of our nursing home associations, we've come together, starting in May of 2020, putting on weekly calls. We have hospitals joining. We have administrators, directors of nursing, home health, assisted living facilities. And it's really set up to provide that just-in-time information. We've all come together to say, we hear you, we support you, we're all in this together. We want to know your concerns. Novel virus, we're all learning together. Dr. Martin, do you want to mention the ECHO program?

Marina Martin, ...: The CARES Act, funded by Congress to support response to the COVID-19 pandemic, included some funding for the agency for healthcare research and quality, AHRQ, and Institute for Health Improvement, who then contracted with a group called Project Echo or the Echo Institute, which is based out of the University of New Mexico and has extensive experience over the past couple of decades educating providers, connecting them to experts so that they can help manage conditions, get the education and support that they need, even though they're far apart.

So they set up this national program to try to reach every nursing home in the country. And that included funding, which is critical because people, as much volunteerism and goodness of heart as we seen during the COVID pandemic, people also have jobs. There needs to be time in their job to do this work. Each state could develop hubs that were locations that the experts that then would set up weekly Zoom calls with cohorts of nursing homes in their state, around 30 nursing homes at a time. Each week had a curriculum that in part was developed by the Institute for Healthcare Improvement to really help support the nursing homes with all the knowledge they needed.

There was a lot of community support where people could speak up and ask questions. Be like, what are you doing in response to this? How do you do isolation and red zones? From the most basic to the most complicated topics about how to respond to COVID, those all came up. We ended up having a partnership between HSAG, which Jennifer has directed that part, to the Health Services Advisory Group and Stanford Medicine and Stanford Continuing

Medical Education office to offer this to our nursing homes that they reached. They don't really talk to each other normally. So this was a chance for them to meet each other and be like, oh, you struggle with the same things I do or share ideas, not reinvent the wheel in the middle of a crisis.

Ruth Adewuya, M...: Sounds like a community of practice has been fostered through this pandemic. It speaks to the heart of the staff who are in organizations and how they are pushing through all of those barriers to still connect and still show up to the weekly meetings. Just an incredible display of passion and humanity in a really difficult situation.

So as we wrap up our conversations, it will be remiss of us if we don't talk about vaccines. Dr. Martin, you mentioned earlier that the uptake of vaccines in residents was pretty good. But we know that despite the fact that these really passionate and dedicated staff members did their work, there was 56% of them vaccinated, higher in California, but still leaving a lot of folks unvaccinated.

I will say, however, that we're recording this August 18 and there's a mandate for vaccinations in senior nursing home facilities and so this might actually change the response to this question moving forward. But I'm curious to hear from both of you, what do you think are the factors that drive vaccine hesitancy in nursing home staff? And what initiatives can be targeted to individuals to raise vaccine confidence? Dr. Martin, can you start?

Marina Martin, ...: Sure. I think, as I mentioned before, nursing homes have kind of been on an island by themselves where they've not been really fully integrated into the healthcare system and into the same culture of healthcare as hospitals and clinics. What we've seen in hospitals and clinics is that there is very strong support, but they haven't benefited from that kind of sharing of that culture and that positive support and talking to a lot of other people who were going to get the vaccine or who got the vaccine to develop confidence in it.

And instead of many of the people who work in skilled nursing facilities may have come from underrepresented minority populations, immigrant populations, who've had to endure a lot of built-in hardship in our system and mistreatment. And so when you then get somebody saying, you have to take this vaccine, when you come from this background in which if you haven't always gotten the greatest and most kind advice from the system, it can be hard to trust.

Within each facility as well, there's this modeling that happens where sometimes the leadership in a facility is very good and supportive and has gotten vaccinated and helps people think through their various barriers. And sometimes that's not the case. Then instead there's a spread of, well, if you're not going to do it, I'm not going to do it, kind of reactions. So it can be very dependent on the individual facility.

Jennifer Wiecko...: We've been polling our nursing homes to get ideas of what they're facing, what their challenges are. And there's this awesome toolkit out there from AHRQ, the Agency for Healthcare Research and Quality. It's called Invest in Trust. And what I read in there resonates with what I'm hearing in the field from my team members who are working with the nursing homes. And some of the major concerns is fertility, pregnancy, breastfeeding concerns. The CDC just came out with new news last week that it is acceptable and safe for pregnant or soon to be pregnant individuals to get the vaccines.

Another reason is worried about side effects, which might cause them to miss work or not be able to care for their young children. And another big reason for not getting vaccinated is that they've already had COVID, they're COVID recovered. They feel protected. They feel that the antibodies are stronger than the vaccine.

So a lot of our work in education opportunities that we touched on earlier is to help bust some of these myths and give leadership the talking points so that they can get over that hump and help people feel more comfortable. Motivational interviewing is a great tactic to use to not say, you're wrong, I'm right. But it's trying to lead people to that ultimate conclusion. That the best thing for me would be to get the vaccine. I will say for California, we're one of the most successful states in the country with 83% of residents vaccinated and 81% of staff vaccinated.

Ruth Adewuya, M...: That's incredible to hear. And hopefully those numbers continue to increase in terms of vaccination rates. Dr. Martin, I'm curious on a personal note how you take care of yourself during this past year and a half caring for elderly patients, the loss of patients. How do you take care of yourself?

Marina Martin, ...: That's something I think that I'm still working on and probably all of us are still working on to some degree and figuring out in our own lives and our own challenges. Having worked with older adults, I've learned that the people who've aged well and lived good fulfilling lives in the latter half of life have generally been people who exercised, at least walked a lot, eat well and try to sleep and sleep well, and stay socially connected. Socially connected, but connected in general. Connected to meaning, to faith, to friendships, to family.

And so those basics are what I've gone back to again and again. And I think they're the same for all of us, really, no matter what our stresses and strains are. And you need to do all of that. You can't work a hundred percent of the time, nor should you. Making sure that you take care of all those other things as well is just critical to your wellbeing and the wellbeing of everyone you take care of when you do work.

Ruth Adewuya, M...: I think it's important to highlight that fact that your own wellness impacts your patient's wellness as well.

Marina Martin, ...: It does. There's no separation.

Ruth Adewuya, M...: Last question for both of you. What are some takeaways or key takeaways for clinicians about the management of nursing home patients? Jennifer, I'll start with you.

Jennifer Wiecko...: I can't believe we've been in this pandemic for 18 months now. The Delta variant is plowing through and there's just no words that give justice to what our nursing homes and our clinicians and our residents and our families have suffered through. My key takeaway for those listening who are on the frontlines, I just want to say thank you for your courage and bravery and the leadership that you've shown and commitment and dedication to ensure that our most vulnerable population in our state and our nation are taken care of.

But I will say with the Delta virus, just seeing how this is going through my own community right now, just the importance of screening. The slightest cough or sniffle or any indication of COVID, a headache, we have to watch for that and you have to take care of one another and where our masks and get vaccinated. The more that we come together as a community and get vaccinated and do those simple things, not just in the nursing home, but also when we're outside of those doors in the community, at the market, that we're putting everybody's interests first.

Ruth Adewuya, M...: Excellent. Thank you. Dr. Martin?

Marina Martin, ...: One of the key takeaways from my experience of this last year and a half is how important it is for doctors, nurses, all of us to really know more about and connect more with the care that occurs in skilled nursing facilities. They're a really important part of a patient's care experience. And the staff and residents and family who are experiencing skilled nursing really need doctors, their healthcare team, to be connected to that, to know what's going on, to feel free to call and speak to somebody at the skilled nursing facility. They would love to talk to the doctor from the hospital or the primary care doctor or the nurse who works with the doctor, whoever. They're really critical links in the healthcare chain.

Ruth Adewuya, M...: Thank you you both very much for sharing your insights with us today on this topic. Incredible work that you and your teams and others have been doing in these facilities. It's great to reflect back and see where we came from, where we are. And despite the fact that it seems like it's an ongoing thing, there's a lot of work that has been done. Thank you for sharing that with us today.

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