COVID-19: Considerations, Strategies, and Resources for Crisis Standards of Care in Post-Acute and Long-Term Care (PALTC) Facilities

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Acknowledgements

Alexis Roam, MSN, RN-BC, DNS-CT, QCP
Curriculum Development Specialist
American Association of Post-Acute Care Nursing (AAPACN)

Diane Sanders-Cepeda, DO CMD
Senior Medical Director
United Healthcare Retiree Solutions

Amy Stewart, MSN, RN, DNS-MT, QCP-MT, RAC-MT, RAC-MTA
Vice President of Education and Certification Strategy
American Association of Post-Acute Care Nursing (AAPACN)

Erin Vigne, RN, MA
Director of Clinical Affairs
AMDA - The Society for Post-Acute and Long-Term Care Medicine

Jim Wright, MD, PhD, CMD
Medical Director
Canterbury Rehab and Our Lady of Hope, Richmond VA

HHS Office for Civil Rights

In addition, this document benefited from close review and comments from the following individuals:

John L. Hick, MD
Medical Director for Emergency Preparedness
Hennepin County Medical Center

Susan M. Levy, MD, CMD
Nursing Home Medical Director and Past President
AMDA - The Society for Post-Acute and Long-Term Care Medicine

Paul Reed, MD, CAPT USPHS
Deputy Assistant Secretary for Health (Medicine and Science)
Office of the Assistant Secretary for Health

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Overview

In response to the COVID-19 pandemic, entities such as nursing homes, assisted living facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities, long-term acute care hospitals, inpatient rehabilitation facilities and dedicated hospice facilities—hereafter collectively referred to as post-acute and long-term care (PALTC) facilities—may need to adjust operations and standards of care in order to preserve and effectively allocate limited facility and healthcare system resources in the face of overwhelming demand due to the national public health emergency response. While a number of [frameworks](), [guidance documents](), and [resources]() are available to help healthcare systems and stakeholders prepare for and respond to the emergence of crisis standards of care (CSC), relatively few address the unique circumstances and information needs of PALTC facilities.

This document provides PALTC facilities an overview of general considerations, potential strategies, and existing resources that they may use to inform changes to their operations and care processes. It is intended to complement, not replace, existing state and/or local guidance and plans for implementing CSC. Similarly, sample tools and resources are provided for illustrative purposes only and should be modified to locally adopted protocols as appropriate.

General Considerations

Continuum of Care, Indicators, and Triggers

- Changes to standards of care should take place along a continuum of levels of care:
  - Conventional: Normal level of healthcare resources;
  - Contingency: Demand for healthcare resources begins to exceed supply but adaptations are possible to still deliver functionally equivalent care;
  - Crisis: Resources are exceeded by demand or depleted; functionally equivalent care is no longer possible to address all requirements and there is a risk to patient/resident or provider.
- Transitions of individuals along the continuum of care do not always occur abruptly, and they do not necessarily effect facility operations and dimensions of care equally and independently. The level of care that can be delivered may be dynamic and shift rapidly or slowly.
  - In fact, actions meant to preserve conventional standards of care in one area of operations may require introduction of contingency or crisis level standards in another area. For example, efforts to conserve staff and PPE resources may require a general shift towards virtual visitations using remote communication technologies, while still allowing access to support persons for individuals with disabilities and compassionate care, including end-of-life visits by family, friends, and clergy.

- Because the level of care that can be delivered may be dynamic and shift rapidly, care processes should be adjusted to match the circumstances (resource availability vs. demand) at a given time, consistent with pre-identified indicators and triggers.
- At all times, adaptations to care processes should involve the minimum adaptation required to meet the needs of the situation. This is meant to keep the risk of the strategy as low as possible.
- PALTC facilities should identify indicators that signal a shift in the level of care that they are able to provide and that trigger changes to standards of care. Triggers should be established in conjunction with state and local partners, including nursing home associations, healthcare coalitions, and public health agencies.

For examples of how facility operations and care services shift under different standards of care, as well as indicators and triggers that facilities could use to guide decision making, see pages 11–15.

Preparedness

- PALTC facilities should have emergency preparedness programs and plans in place that are consistent with any applicable regulatory requirements and national guidelines.
- Nevertheless, PALTC facilities may need to augment their emergency preparedness plans with crisis management protocols that address the unique challenges and threats posed by COVID-19.
  - CDC, CMS, OSHA, and AMDA- The Society for Post-Acute and Long Term Care, have published multiple documents and tools that PATLC facilities can use to assess and enhance their preparedness for COVID-19.
- Advanced planning for alterations in response procedures and in allocation of resources will be required at the contingency level of care, with the primary goal of avoiding a transition into the crisis level of care.
  - PALTC facilities need to establish and reinforce protocols to monitor and manage their resources as the demand increases.
    - For example, reports for monitoring of personal protective equipment (PPE) shortages and supply and maintenance reports should be reviewed regularly in nursing homes. This should be part of the Nursing Homes' Quality Assurance and Performance Improvement (QAPI) meetings with preparation to increase those reviews if the continuum level of care changes.
  - PALTC leadership (e.g., facility administrator, medical director, and director of nursing) and healthcare professionals should ensure that advance care planning has been discussed with the people that they serve including their own staff, with special consideration given to an unfolding healthcare crisis.

- o PALTC facilities' staffing models need to account for increased demands and potentially diminished staff as the level of care changes from conventional to contingency, and as staff may themselves fall ill and/or are otherwise unavailable.
- o Facility policies and operations, including engineering controls, e.g., ventilation and personal protective equipment (PPE) e.g., respirators may need to be (further) adjusted to reduce disease transmission and exposure risks for residents and staff (e.g. limiting visitation to necessary support persons for individuals with disabilities, and compassionate care situations; cohorting residents in non-restrictive environments; cancelling unneeded visits or delaying visits for routine and preventive care; practicing social distancing (6-feet) where possible). Enhanced decontamination of facility surfaces and equipment would need to be implemented

PALTC facilities should contribute to the development and implementation of state and/or local CSC plans, as well as federal, state, and local strategies and initiatives aimed at preventing and responding to crisis scenarios.

Legal

- National and state emergency declarations for COVID-19 may provide additional flexibility, including the waiver and/or suspension of certain federal and state laws and regulations.
  - o The federal government has issued numerous blanket waivers and flexibilities to certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements under its authority pursuant to section 1135 of the Social Security Act, including several waivers and flexibilities that directly pertain to PALTC facilities. It has also taken substantial action allowing and encouraging greater use of telehealth during the COVID-19 public health emergency under the Health Insurance Portability and Accountability Act (HIPAA) and under Medicaid.[1]
- PALTC facilities should ensure that any changes to their operations and standards of care comply with the federal, state, and local laws and regulations in their jurisdictions.
  - o Civil rights laws and regulations are not suspended or waived in the disaster context and continue to apply during the COVID-19 public health emergency.[2]
    - Prioritization of care, including denials of care, must be made after nondiscriminatory consideration of each situation based on the best available objective medical evidence, free from stereotypes and biases based on a person's race, gender, disability or age—including generalizations and judgments about their quality of life or relative value to society. Reasonable modifications to clinical instruments for evaluating

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[1] *See* https://www.telehealth.hhs.gov/providers/policy-changes-during-the-covid-19-public-health-emergency/
[2] For an example of a press release describing the resolution of a complaint applying civil rights laws to crisis standards of care, please see HHS OCR's recent resolution in Tennessee: https://www.hhs.gov/about/news/2020/06/26/ocr-resolves-complaint-tennessee-after-it-revises-its-triage-plans-protect-against-disability.html.

short-term mortality risk for prioritization purposes may be necessary for accurate use with patients with underlying disabilities.[3]

- Reasonable modifications to policies restricting visitations may be necessary to permit access to support personnel[4] who assist people with disabilities, unless such modifications would constitute a fundamental alteration to CSC or would pose a direct threat to others.[5]
- Recipients and subrecipients of certain Federal block grants may not discriminate on the basis of religion, and in some cases, PALTC facilities may need to make reasonable modifications to visitation policies to allow access to clergy and religious exercise on equal terms with secular based exceptions and accommodations.

- PALTC facilities should also coordinate operational adjustments with relevant state, regional, and local authorities—including relevant medical direction.

Ethical

- Standards of care at all levels of care should adhere to core ethical principles, including fairness, duty to care, duty to steward resources, transparency in decision-making, consistency, proportionality, and accountability.
  - The implementation of these CSC guidelines will require active involvement of the facility medical director in order to ensure that ethical principles are properly honored.
    - The Hastings Center has released an Ethical Framework for Health Care Institutions and Guidelines for Institutional Ethics Services Responding to the Coronavirus Pandemic that may be helpful.
- Ethical decision making during the COVID-19 crisis primarily concerns issues of equity and equality. Using resources wisely while still treating all people fairly can prove to be ethically challenging. Healthcare providers strive to be person-centered first, with a recognition of duty to the wider community second.

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[3] *See* HHS OCR's resolutions in Utah and Tennessee that applied reasonable modifications to clinical instruments: https://www.hhs.gov/about/news/2020/08/20/ocr-resolves-complaint-with-utah-after-revised-crisis-standards-of-care-to-protect-against-age-disability-discrimination.html; and the revised Utah policy at https://coronavirus-download.utah.gov/Health/Utah-Crisis-Standards-of-Care-Guidelines-v7-08132020.pdf at 5; https://www.hhs.gov/about/news/2020/06/26/ocr-resolves-complaint-tennessee-after-it-revises-its-triage-plans-protect-against-disability.html and the revised Tennessee policy: https://www.tn.gov/content/dam/tn/health/documents/cedep/ep/Guidance_for_the_Ethical_Allocation_of_Scarce_Resources.pdf. at 21.

[4] Support personnel may be paid or volunteer and may include family members who assist with communication, self-regulation and behavioral support, and other support, which an individual with a disability may require to receive equal benefit from the facility's programs.

[5] A direct threat is defined as a significant risk of substantial harm to the health or safety of others that cannot be mitigated by reasonable modifications to policies, practices, or procedures, or by the provision of auxiliary aids or services. Facilities should bear in mind the scope of available mitigation strategies, such as the use of Personal Protective Equipment, temperature checks and other measures that may enable safe visitation.

- o Nevertheless, when resource scarcity reaches crisis levels, clinicians are ethically justified to prioritize available resources and treatments based on likelihood of immediate or near-term survival with treatments under consideration.
- Truth telling as a foundational ethical principle must also be reinforced during times of crisis.
  - o Facilities must promptly report outbreaks and individual cases to state and local authorities, as well as residents, their representatives and their families.

For an example of how PALTC facilities should put these ethical principles into practice, see Appendix 1.

Advanced Care Planning

- Most people residing in subacute, long term care and assisted living facilities are older adults with multiple co-morbidities including diabetes mellitus, cardiac conditions like congestive heart failure, cardiomyopathy, chronic hypertension, renal failure, COPD, and cognitive impairment such as dementia.[6] These factors place PALTC residents at a higher risk of contracting the COVID-19 virus, as well as experiencing more severe complications of COVID-19, including death.[7]
  - o Nonetheless, elderly residents can still have good outcomes after COVID-19 infection,
- Advanced Care Planning (ACP) discussions that take a patient centered approach are particularly critical to determining patient preference for medical care in the context of the current COVID-19 public health emergency.
  - o ACP should include discussions about wishes not only for resuscitation, but also intubation for COVID-19 (knowing that intubation may be protracted), prolonged and aggressive multi-organ failure support including dialysis, and whether hospitalization is desired.
- PALTC facilities with up-to-date advanced care plans in place for their residents will be better positioned to adapt their standards of care in ways that balance resident preferences and available resources.
  - o AMDA – The Society for Post-Acute and Long Term Care Medicine offers an Advance Care Plan (ACP) Tool that facilities can use to structure and guide ACP discussions.
- While providers may revisit ACP discussions with residents, they must be careful not to exert pressure on residents with disabilities or older persons to decline life-sustaining treatment.

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[6] Manton, Kenneth G., Cornelius, Elizabeth., Et.al. The Nursing Home Residents. A multivariate analysis of their medical, behavioral, psychosocial and service use characteristics. The journal of Gerontology: Vol.50A; Issue 5; Sep 1995, 242-25. https://doi.org/10.1093/gerona/50A.5.M242.

[7] Zhou.F.,Yu,T. Et.al. Clinical course and risk factors for mortality of adult inpatients with COVID-19 in Wuhan, China. A retrospective Cohort Study. Lancet 2020, March 28: 395 (10229):1054-1062; Gupta S, Hayek SS, Wang W, et al. Factors associated with death in critically ill patients with Coronavirus Disease 2019 in the US. JAMA Intern Med. Published online July 15, 2020. doi:10.1001/jamainternmed.2020.3596. .

Diversion and Transition

- Providers should work with families and state or local partners like the [Area Agencies on Aging](#) and [Centers for Independent Living](#) to ensure individuals and families are adequately informed about non-institutional options for accessing long term care services and support, including home and community-based service options.
- After admission, providers should periodically re-evaluate the need for residents to remain in a congregate care setting and inquire as to resident preferences on the question and discuss alternatives.
  - See HHS Office for Civil Rights existing [Guidance and Resources for Long-Term Care Facilities: Using the Minimum Data Set to Facilitate Opportunities to Live in the Most Integrated Setting](#)
  - The Administration for Community Living (ACL) [Long-Term Care Ombudsman Program](#) can also help address questions and barriers regarding transitions.

Communications

- Communication is one of the most important parts of crisis management. In corporate crisis communication, effective, timely, and transparent communications are critical to maintaining the trust of patients and families. [Letters](#) or other communications with residents and their families should, for example, explain the steps a PALTC facility is taking to limit adverse impacts on its residents and other affected stakeholders and illustrate how steps align with CDC or other Federal and state guidance.
- Long-term care facilities dealing with COVID-19 or a similar crisis can minimize the potential for miscommunication and frustration by establishing communication channels and partnerships with their stakeholders, which include, but are not limited to: residents and their families; facility staff; vendors and other facility service providers; community healthcare providers, such as local hospitals and home health agencies; and public health departments.
  - Ideally, channels of communication are established long before a crisis emerges to avoid frustration, miscommunication and inefficiency.
  - Provider communication with residents and families should detail how they will support on-going resident and family care if in-person visits are limited: for example, scheduling times for virtual visits or assisting with phone calls.
- Because crisis communication of health information must be complete, transparent, and compliant with HIPAA privacy and security regulations, planning is best handled by a team that includes medical (e.g., medical director, director of nursing), administrative (e.g., nursing home administrator), and legal and communications representatives.[8]
  - However, to ensure consistency across communications, one individual should coordinate the communication for the team whenever possible.

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[8] See https://www.hhs.gov/hipaa/index.html.

For an overview of elements that need to be addressed by the crisis communication team as part of its plan, see Appendix 2.

Sample Continuum of Care

The table below illustrates how facility operations and delivery of care and management services might shift under different care standards. It is not intended to be prescriptive; rather, it is meant to demonstrate how conventional, contingency, and crisis might manifest in practice.

	Conventional	**Contingency**	**Crisis**
Standard of Care	• Normal or usual care and services provided. ○ Care delivered based upon the resident's wishes, as outlined in the plan of care	• Functionally equivalent care, but may be delayed or adapted	• Crisis care

Space	• Census is stable
	• Facility has enough space to quarantine new admits/readmits and isolate infected residents
		• Census change variant—potential growth from increasing hospital admissions; potential declines for transfers to area hospitals
		• Number of residents/patients with COVID-19 requires some contingency actions (e.g., more extensive within- or cross-facility transfers)
			• Census declines as residents with acute care needs are transferred, and new admissions and readmissions are deferred
			• Large number of residents with confirmed or suspected COVID-19 requires:
			  ○ use of non-certified beds or other spaces within the facility (e.g., communal dining areas), and/or
			  ○ transfers to non-certified alternative care sites (ACS) within the community

Staff	• Staffing ratios based on the resident assessment and care plan, as well as any state requirements	• Extended shifts, additional shifts, and/or change in allocation of staff	• Unable to meet registered nurse coverage regulations; • Significant change in certified nursing aide and nurse to resident ratios; and/or • Utilization of ancillary staff in supportive caregiving roles

Supplies	• Normal par levels of all supplies with access to supplies that are provided by off-site vendors	• Conservation, adaptation, substitution, and extended use strategies in place for certain supplies, in accordance with national recommendations	• Additional optimization strategies adopted, including
			  ○ rationing select supplies and services;
			  ○ using non-standard supplies[9]; and
			  ○ decontaminating and/or reusing PPE

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[9]If healthcare personnel use respirators certified in accordance with the standards of other countries and jurisdictions, the respirators must also be permitted for use in healthcare under a U.S. Food and Drug Administration (FDA) emergency use authorization. *See* https://www.fda.gov/medical-devices/coronavirus-disease-2019-covid-19-emergency-use-authorizations-medical-devices/faqs-euas-non-niosh-approved-respirators-during-covid-19-pandemic

Sample Indicators and Triggers

This table provides *sample* indicators, triggers, and tactics for PALTC facilities. The indicators, triggers, and tactics shown in the table are intended to help demonstrate the kinds of information and level of detail needed to develop useful indicators and triggers for a specific organization; they are not intended to be comprehensive or adopted wholesale without question. As a reminder, *indicators* are measures or predictors of changes in demand and/or resource availability; *triggers* are decision points.

	Contingency	Crisis	Transition to Conventional
Surveillance Data	**Indicators:** • X[10] or more new COVID-19 suspected and confirmed cases in the last week, or 1 confirmed resident case in a facility that was previously COVID-19 free • County positivity rate in the last week > 5% **Triggers:** • Suspected/confirmed new onset of resident infection • Public health alert that community cases are rebounding **Tactics:** • Anticipate activating the emergency plan and standing up an incident command to support its implementation • Relevant state and local authorities, including health department, notified of new positive or presumed positive resident case	**Indicators:** • X cases or X% of residents have suspected or confirmed COVID-19, and the facility is not dedicated to COVID-19 care • County positivity rate in the last week > 10% **Triggers:** • Weekly number of cases in community spiked rapidly • Number of cases in facility increasing week over week, signaling growing outbreak • **Tactics:** • Initiate the emergency plan, which includes activation of incident command system, and the crisis communication plan	**Indicators:** • 28 days have lapsed since last resident COVID-19 positive or presumed positive case • Downward trajectory (with no rebound) of confirmed COVID-19 cases in the community for three consecutive, 14-day periods **Triggers:** • Community and facility case status meets criteria for entry to phase 3 of Opening Up America Again and CMS' Nursing Home Reopening Recommendations for State and Local Officials, respectively **Tactics:** • Continue to collect surveillance data related to COVID-19

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[10] Given the diversity of care and services provided in PALTC facilities, as well as the various populations they serve and contexts in which they operate, this document uses "X" to identify where specific, quantitative targets might be appropriate and useful. Facilities can customize the values based on state requirements, resident acuity, and other factors. SNFs may, however, choose to use the CMS guidance in Memo #QSO-20-31-All as a starting point, where applicable.

	Contingency	Crisis	Transition to Conventional
		• Relevant state and local authorities, including health department, notified of situation	
Community and Communications Infrastructure	**Indicators:** • Resident communication/contact with family, friends, and some (typically onsite) service providers (e.g., physical therapists) is limited in terms of visitor numbers, frequency, or modality (e.g., outdoor vs. indoor visits) • X% of local referral hospitals' ICU and/or inpatient hospital beds filled **Triggers:** • Staff shortages or facility circumstances (e.g., outbreak) limit in-person visits by family, friends, clergy and some non-essential service providers, except when needed to ensure that people with disabilities are not denied reasonable access to needed support persons, and in and compassionate care situations • Referral hospitals have communicated they are functioning under contingency standards of care **Tactics:** • Implement innovative methods to help residents remain connected with family, friends and one another while maintaining robust infection control practices • Leverage telehealth to help maintain resident access to specialty care providers	**Indicators** • Resident communications with family, friends, representatives, and non-essential service providers is limited, even through virtual/audio means • X% of local referral hospitals' ICU and/or inpatient hospital beds filled **Triggers** • Extreme staff shortages limit personnel availability to support critical communications functions (e.g., resident virtual visits with family; telemedicine visits with non-essential service providers) • Referral hospitals have communicated they are functioning under crisis standards of care **Tactics:** • Request administrative and communications support from state and local authorities, corporate office, or local/regional healthcare coalition partners • Collaborate with state/local authorities and healthcare coalition stakeholders (including EMS and hospitals) to establish alternative care sites to help manage patient surges and transfers between acute and PALTC settings	**Indicators** • Resumption of in-person visitation allowed for resident friends, families, clergy, and non-essential healthcare personnel and contractors • X% of local referral hospitals' ICU and/or inpatient hospital beds filled **Triggers** • Facility entry and in-person visitation allowed with screening and additional precautions (e.g., face mask/cloth face covering for visitors) • Referral hospitals have communicated they are functioning under conventional standards of care **Tactics** • Ability to use standard communication and reporting mechanisms reestablished • Routine protocols and processes for resident transfer/transport between acute and PALTC settings

	Contingency	**Crisis**	**Transition to Conventional**
	• Monitor hospital capacity and coordinate threshold for EMS transport when needed based on healthcare system demand		
Staff	**Indicators:** • Increased staff absenteeism • Certified nursing aide (CNA and licensed nursing staff to resident ratios reach X **Triggers:** • Increased staff absenteeism (due to staff infections, low morale, or social factors like transportation or housing) • Management/owner and state/local agencies notified of decrease in nursing staff to resident ratios **Tactics:** • Cancel non-essential business and redirect staff to focus on direct resident care • Notify PRN[11] pool of the potential shortage and begin scheduling coverage (require dedicated PRN staff to avoid cross-contamination)	**Indicators:** • Contingency staffing strategies maximized • CNA and licensed nursing staff to resident ratios reach X **Triggers:** • Staff absenteeism exceeds ability to provide contingency care • Management/owner and state/local agencies notified nursing staff to resident ratios fall below regulatory thresholds **Tactics:** • Utilize healthcare and trained ancillary workers (e.g., CNA students, physical and occupational therapy providers) to provide supportive care as allowed by state and federal authorities • Request state assistance from the National Guard and other government entities • Utilize office and other ancillary personnel to assume supportive duties, such as communication with families and serving meal trays	**Indicators** • Absentee rates have returned to contingency level with trend toward conventional care levels • CNA and licensed nursing staff to resident ratios return to mandated regulatory levels or pre-crisis operating levels, whichever is greater **Triggers:** • Temporary PRN[11] float pool and other emergency staffing sources are not required **Tactics:** • Maintain PRN float pool and relationships for staffing sources in case of a future outbreak

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[11] PRN is an acronym for the Latin pro re nata, which translates to "as the situation demands." These staff serve as on-call or temporary personnel.

	Contingency	Crisis	Transition to Conventional
		• Utilize PRN[11] float pool (require dedicated PRN staff to avoid cross-contamination)	
Supplies and Equipment	**Indicators:** • [PPE burn rate] • Onsite supplies for critical medications and supplies adequate, but order fulfillment times exceed historical average by X days **Triggers:** • Contingency preservation strategies for PPE and medications initiated to stretch available supplies until next delivery **Tactics:** • Implement [CDC-recommended] contingency strategies such as extended use of N95s and face masks • Collaborate with pharmacy and other vendors to forecast needs and ensure adequate supply of required medications and medical supplies (e.g., catheters, oxygen cylinders and concentrators)	**Indicators:** • Current PPE inventory inadequate even with contingency measures in place and timeline for resupply unknown • Access to critical medication, including IVs, is limited to one-week supply or less **Triggers:** • PPE is unable to be obtained and facility levels require crisis preservation strategies • Pharmacy has notified facility of shortages of medications **Tactics:** • Implement [CDC-recommended] crisis strategies such as limited reuse of N95s and face masks • Ration use of critical medications/medical supplies • Collaborate with pharmacy to substitute available medications for those that are unavailable	**Indicators:** • PPE supplies are sufficient to meet demand without conservation strategies • Critical medications are available on site in sufficient quantity to meet demand **Triggers:** • Regular orders of PPE and medications are fulfilled at contingency level with trend toward conventional level **Tactics:** • Stockpile PPE, and maintain relationship with multiple sources who can provide PPE in case of future outbreak

Preventing and Responding to Crisis Standards of Care

As previously mentioned, advanced planning and preparedness, combined with ongoing situational awareness and vigilant tracking of key indicators and triggers, is essential to averting CSC where possible—and responding to CSC in ways that maximize resources and ensure that the needs of patients, clients, and residents are met. There is, of course, no single, "best" way to avoid or minimize the potential harms associated with transitions to contingency and crisis care standards. However, PALTC facilities do have multiple strategies available to them to proactively adapt operations and conserve, substitute, move, or reuse resources in ways that prevent or delay the need for CSC as long as possible.

The following sections offer examples of the kinds of strategies that PALTC facilities might adapt or adopt when contingency and crisis standards of care are anticipated or triggered in the following domains:

- Response and Operations
- Daily Care and Activities
- Medical Care and Treatment
- Transport and Transfer

Response & Operations

- The PALTC facility's emergency preparedness program and supporting emergency operations plan (EOP) should address the unique challenges presented by COVID-19 including but not limited to: potential staffing shortages and limited resources; crisis communication; significant modifications to operations to prevent the spread of the virus; and coordination with other hospitals, PALTC facilities, local government, and PALTC organizations.
  - o PALTC facilities should review their current plans and response structure to ensure they position the organization to rapidly identify and adopt operational shifts aimed at avoiding transitions to contingency or even crisis standards of care.

Potential Strategies

- Develop and institute an Incident Command System (ICS)
  - o Form an Incident Management Team (IMT) that includes a designated leader (incident commander), key command staff (including the infection preventionist and medical director), and designated staff charged with managing operations, logistics, planning, finance, and administration.
    - ▪ The Infectious Disease Response Guide from Nursing Home Incident Command System and Appendix 3 of this document offers additional details about the roles and key responsibilities of each team member.
  - o Use the facility's existing emergency plan to develop and institute an Incident Action Plan (IAP) that addresses the unique challenges presented by the COVID-19 pandemic and:
    - ▪ Considers the organization's mission, policies, procedures and EOP;
    - ▪ Takes stock of and accounts for, the current situation based on available data and assessments;
    - ▪ Establishes incident objectives according to the principle of Management by Objectives;
    - ▪ Determines appropriate strategies to achieve the objectives;
    - ▪ Gives tactical direction to facility staff and others and identifies mechanisms to judge their effectiveness; and
    - ▪ Identifies the support needed to institute and refine or revise elements of the IAP based on evolving conditions.
- Develop new, or repurpose existing, systems to monitor and proactively identify potential shortages in critical internal and external resources, such as staff, PPE, testing supplies (e.g., swabs), and body bags.
- Institute administrative and operational infection prevention controls that preserve and conserve available resources, including staff and PPE, by reducing resident and staff risk of exposure to, or transmission of, COVID-19. These include, but are not limited to:

- o Restricting visitor entry[12] and building access points;
- o Repurposing existing space within the facility (e.g., dining rooms or visiting areas) to create observation units for residents with suspected COVID-19;
- o Changing infection control standards to permit group isolation (i.e., cohorting) for confirmed cases of COVID-19 or other communicable diseases rather than single person isolation unit; and
- o Moving residents with confirmed COVID-19 to dedicated spaces within the facility and assigning dedicated staff to work in that unit.
- If shortages begin to emerge, institute conservation and risk mitigation strategies, such as:
  - o Activating local, regional, and state partners and partner networks, including health departments and healthcare coalitions, for assistance addressing staffing, PPE, testing, and other critical resource shortages;
  - o Extending use, reuse, or prioritization for certain activities of PPE including gowns, facemasks, respirators, gloves, and eye protection;
  - o Changing staffing patterns and increasing hours in ways that prioritize ongoing service provision for direct resident care needs;
    - ▪ To help staff accommodate these changes, PALTC facilities may need to provide additional support in the form of onsite housing, negotiated access to local day care provider services, and transportation.
  - o Expanding the roles of existing staff;
    - ▪ Expanded staff roles should occur incrementally and only for as long as necessary. Those performing expanded roles should be under the supervision of an experienced, licensed MD, DO, APRN, RN or other person of appropriate discipline for the specific types of care, who delegates and directs a team of healthcare workers and oversees a patient caseload.
  - o Allowing asymptomatic staff with confirmed COVID-19 to provide direct care for residents/patients with confirmed COVID-19, preferably in a cohort setting; and
  - o Implementing regional plans to transfer patients with COVID-19 to designated healthcare facilities, or alternate care sites with adequate staffing and resources for the patient.
- Collaborate with key healthcare and public health stakeholders in the community (including other PALTC facilities, local and regional hospitals and health systems, and state and local health departments) to institute medical operations coordination cells (MOCCs) or other, similar coordination and communication structures that:
  - o Act as a single point of contact for requests from multiple stakeholders such as healthcare facilities, and
  - o Facilitate movement of patient and resources (e.g., PPE and staff) across the health system to better align demand and capacity for supply.

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[12] See subsequent sections on daily care and medical care and treatment for strategies to minimize the impact this operational strategy may have on resident healthcare access and quality of life

- Modify the crisis communication plan to prevent gaps or lack of communication to authorities, residents and resident representatives, and other stakeholders.
- Take steps to prevent staff burn out, encourage staff self-care, and support staff physical, mental, and emotional resilience.

Daily Care and Life Enrichment

- It may be necessary to modify the provision of activities of daily living (ADL) and resident life enrichment activities during an emergency or crisis—particularly if social contact between staff and residents and among residents could create opportunities for ongoing disease transmission. However, infection control and prevention practices enacted to prevent the spread of COVID-19 may have an adverse effect on physical, mental, and emotional health.
  - For example, communal dining and other group activities may be suspended, and times of showering/bathing may be altered due to staff changes, staff shortages, and PPE shortages.

Potential Strategies

- Healthcare providers (e.g., nurses, nursing assistants, resident care providers) providing personal care for residents must be given priority for PPE and testing.
- Person-centered care plans and service plans can be modified to address the unique challenges and threats to psychosocial and psychological health and wellness related to infection control and prevention measures in place to prevent the spread of COVID-19.
  - For example, routines are very important for residents with dementia, so PALTC facilities need to carefully consider potential risks and benefits of moving residents out of the memory care unit to a designated COVID-19 care unit.
  - The abbreviated service plan form available in Appendix 4 provides an example and template which can be included as a standalone resource to communicate with staff or incorporated into the care plan.
- In addition to the modification of individual plans, a facility engagement plan should address how life enrichment activities will overcome the unique challenges infection control and prevention practices related to COVID-19 present including but not limited to: social distancing, room isolation, absence of communal gatherings, and the lack of intimate/familial touch that accompanies the physical presences of loved ones.
- Find new ways to help residents remain physically, mentally, and socially active and connected, such as:
  - Ask the resident to march in place or do sit-to-stand or range of motion exercises (with appropriate safety precautions) while helping him/her get his/her clothes out
  - Help residents to access and follow range of motion exercise videos in their rooms during ADL care
  - Ask residents to stand at their doors (every other room to start, then switch to group two to increase distance between residents) and lead them in stretching and balance exercises as appropriate.
  - Play music in the hallways for residents to hear, or play live or recorded music outside in a courtyard where residents can watch and listen from their rooms.

- o Find additional inspiration at #CareNotCovid and take advantage of the Pioneer Network's *ABCs of Combating Isolation* resources.
- o The National Certification Council for Activity Professionals has a wealth of information specific to supporting resident activities during Covid-19, including 101 Ideas for In-Room & 1-to-1 Activity Programs.
- o An individualized approach may be needed to ensure individuals with physical and intellectual disabilities have the same level of access to alternative activities.
  - For example, adjustments may be needed to address limited mobility and difficulty accessing information, trouble understanding information, and/or difficulties with changes in routines.

- Reconfigure existing spaces to support socially distanced communal activities and dining, such as spacing dining chairs so residents may eat together while maintaining at least 6 feet of distance between one another
  - o Facilities should ensure any in-person communal activities adhere to core principles and best practices that reduce the risk of COVID-19 transmission (e.g., appropriate hand hygiene and use of a face covering)
- Verbally and visually cue residents to participate in as much of their care as possible.
- Provide alternative means of communication--such as video chat, telephone, texting or social media—and (where necessary) staff assistance for residents to contact their loved ones
  - o For residents with dementia, a phone call or videoconference a few times a week may not be sufficient; consider using a simulated presence.
  - o Be sure to clearly and proactively communicate these alternatives—and the facility's reasons for shifting from in-person to virtual visitation--to residents and their families.
- Create accessible and safe outdoor spaces for visitation, such as in courtyards, patios, or parking lots, including the use of tents, if available

Medical Care and Treatment

The medical care and treatment rendered to residents in an emergency or crisis should be designed to assure appropriate and effective responses to a variety of situations and conditions. The overall purpose is to provide person-centered care, while ensuring the safety of facility staff.

General Care Guidelines

- Facilities should have a plan for triaging care if needed, with a focus on
  - Provision of essential supportive services including nutrition support, personal hygiene and safety
  - Administration of only essential medications and treatments
  - Comfort care, including fluids and pain management
- Medical care and treatment provided in PALTC facilities should be based on current clinical guidelines, including updated COVID-19 recommendations and treatment protocols/information from appropriate public health authorities and other organizations and professional societies (e.g., Infectious Disease Society of America), as well as the judgment of practitioners in the facility.
- When a resident becomes ill, decisions about where and what kind care (i.e., palliative or lifesaving) is provided should be determined by his or her condition and care goals, as well as current PALTC facility and/or hospital capacity to provide the desired level of care. Communication with family or resident representative is essential.
- Where possible, facilities should minimize in-person and follow-up care visits with external consultants who may be visiting other facilities (e.g., podiatry, wound care, dental). Instead, facilities should expand access to and usage of tele-medicine and online evaluations for primary, specialty, and emergent care.
  - Expanded use of these and other technologies that support alternative care models (e.g., wearables that allow remote patient monitoring of blood pressure, blood sugar, or oxygen saturation) can help residents maintain access to the care they need while minimizing exposure risks for residents, staff, and service providers.
  - The decision to have in-person visits should be made by assessing risks and benefits on case by case basis in accordance with residents' goals of care (e.g., critical surgical, vascular, and/or cardiac procedures). Communication between facility practitioners and outside consultants will be needed to minimize risk.
- Staff, nursing assistants and therapists may need to assume roles of care that are not within their typical responsibility, but that do not violate their legal scope of practice or mandates for training.

Potential Strategies

- Review which residents who do not have advanced directives and have informed discussions with those residents and/or their representatives to obtain advanced directives.

- In residents who have tested positive for COVID-19, practitioners should have a goals of care discussion specific to the disease.
- Focus on proven medical interventions and therapies that provide benefit; forgo those interventions that lack clear evidence of benefit or have high resource utilization in all residents.
  - Optimize medication management by de-prescribing any unnecessary medications (e.g., multivitamins), simplifying medication regimens or their administration (e.g., consolidating administration times or changing timing for doses).
  - Reduce nursing care requirements by adjusting the frequency of prescribed medical orders (e.g., routine yearly TSH orders for resident with stable hypothyroidism) or extending the interval between administration (e.g., extended release preparation of antihypertensive in lieu of multiple doses of short acting medication)
    - Monitor for changes if dosage intervals change.
- Collaborate with pharmacies and vendors to forecast needs and ensure adequate supply of critical medication and medical supplies, such as:
  - Morphine (liquid) with backup of oxycodone and hydrocodone and fentanyl patch.
  - Antianxiety agents
  - Corticosteroids
  - Antibiotics
  - IV fluids
  - Urinary catheters which may be used for comfort during crisis care
  - Oxygen and oxygen supplies (large cylinders and concentrators, regulators, delivery devices)
- Emphasize nutrition, hydration, skin and mouthcare.
  - Promote nutrition modifying and liberalizing diets if necessary and offering liquid caloric supplements.
  - Combine multiple tasks in one interaction—for example, monitoring of pulse oximetry, offering hydration and turning of the resident can all be done in one visit with proper infection control measures.
- Provide recommended management and supportive care to residents with suspected and confirmed COVID-19 in accordance with their goals of care
  - Support respiratory symptoms with supplemental oxygen (high flow oxygen may be needed) and bronchodilators (metered dose inhalers with or without spacers, oral, or in nebulized forms).
    - Staff should make all efforts to minimize disease transmission during high risk procedures that can cause aerosolization.
    - Use of steroids and antibiotics may be warranted in some patients. Symptomatic treatment of dyspnea with opioids may also help generalized pain.
  - Uncommon gastrointestinal symptoms may need symptomatic management.
  - Support metabolic encephalopathy and poor oral intake with frequent oral hydration.

- Hypodermoclysis or intravenous fluid support may be required especially in residents with underlying dementia and failure to thrive.
- o [Consider thromboembolic prophylaxis](#) with subcutaneous low molecular weight heparin.

Transport and Transfer

- Emergency or crisis situations may require modification of where residents receive care and other services, as well as how they get to service sites. This may include deferral of transport for sub-specialty evaluation for non-emergency conditions (e.g. ortho, eye evaluations) as well as changes to the threshold for transport for acute evaluation and treatment.
- During the COVID-19 response, PALTC facilities may need to modify their current EOP to incorporate alternative strategies and standards for different kinds of transport and transfer, including
  - o Internal transportation, such as moving residents between rooms or floors as a result of crisis conditions; and
  - o External transportation under common scenarios that present potentially unique considerations (e.g., emergency transfer/EMS or death).
- PALTC facilities should work closely with hospitals, funeral homes, emergency medical services, and other stakeholders to develop new, or modify existing, policies and procedures around external transport and transfers.
  - o EMS agencies may be significantly delayed responding to requests for assistance, particularly non-emergency transfers.
  - o Healthcare facilities may become overwhelmed with patients, making it necessary to consider alternative options for managing patients who would be otherwise transported to the hospital under normal circumstances.
  - o The status of local hospitals and ACS facilities should be communicated and updated continuously to the facility leadership, in order to inform transport destination decisions. In rapidly evolving scenarios, local, state and regional access to care sites is likely to be dynamic and frequently changing.
  - o Disposition of deceased residents may be an issue due to funeral homes and crematoria at full or more capacity. A contingency should be developed to accommodate removal of the deceased.
- In all situations, the goal remains to ensure and provide appropriate, effective response to the emergency or crisis that secures the safety of residents, staff, and visitors at all times.

Potential Strategies

- Establish a process and system to track current capacity and open beds across health care facilities
  - o Under an ideal scenario, this would be developed and maintained on a state-wide basis by the department of health (e.g., MNTrac)
- Determine if there are facilities that will house residents with suspected or confirmed COVID-19 and establish protocols and processes for transporting/transferring COVID-19 residents there

- Identify locations that could be used if needed to house and care for affected residents, including areas that may not typically be used for resident care.
  o Ensure that the location meets all federal and state regulations for alternative care sites and is appropriate for the care of the patient.
- Establish dedicated sites for resident pick-up and drop-off (e.g., following return from a dialysis or chemotherapy appointment).
- Notify local hospitals and other settings if the facility is closed to admissions and readmission while operating at a crisis standard of care
- Work with local resources on community alternatives, consistent with the community integration mandate under the Supreme Court's decision in *Olmstead v. L.C.* that services (including community-based services) must be provided to persons with disabilities as appropriate and desired by the individuals, with reasonable accommodations as available.
  o For example, partner with home health agencies to identify options that would support continuity of care while allowing safe discharge of residents to their homes
    ▪ Make referrals to other entities with expertise in community based services and supports such as the Centers for Independent Living, Area Agencies on Aging, the Long-Term Care Ombudsman.
- In collaboration with area hospitals, nursing homes and funeral homes, develop a plan for care of the resident after death including how the resident will be identified and post-mortem care.
  o Determine who will notify the family and how that notification will occur.
    ▪ Notification processes should offer families both critical information and grief support
  o Discuss with the partners who will be in charge; how critical post-mortem supplies will be maintained; and security measures
  o Identify a central location where deceased can be transferred if morgues are overwhelmed (e.g., refrigerated warehouses or trailers that can function as temporary morgues)
    ▪ If using a military site – have agreement with military to provide personnel to provide security for storage areas.
    ▪ Predetermine who will be monitoring the arrivals and departures of the deceased at the central location site (could be representatives of funeral homes)
    ▪ Design a tracking log to enter all names of deceased and location at storage area and final disposition, date, time and who the body was released to.
    ▪ Include notification of family of arrival and disposition
  o Develop protocols for aftercare of the body that ensure minimal exposure to transport personnel, such as:
    ▪ Identifying the deceased by labeling the body and the covering (include family name and phone number for notification).
    ▪ Placing the body in a body bag, casket cover, shroud, or even sheets.

Appendix 1: Ethical Considerations—a Practical Example

An example of the tension between equity and benevolence towards individuals while also treating the entire community fairly or equitably is demonstrated in the use of inhaled bronchodilators in the PA/LTC setting:

- It is suspected that use of nebulizers increases the risk of aerosolizing COVID-19 virus, thereby increasing the risk of transmission to front line staff (CNAs, nurses, and healthcare professionals). The use of metered dose inhaler's (MDIs) with spacers can mitigate the risk of aerosolizing viral particles and show equal efficacy in treating bronchospasm in most patients.

- Some residents, however, especially those with cognitive impairment, may not be able to coordinate inhalation with the actuation of a metered dose inhaler, even with the use of a spacer.

- If the resident clearly benefits from nebulizer treatment compared to MDI use, one must choose between patient-centered care (the use of nebulizer treatments) versus one's duty to the wider community (protecting front line staff by prohibiting any nebulized treatments in the PA/LTC setting).

Some institutions have responded to this dilemma by establishing blanket prohibitions against the use of nebulized bronchodilators, even though this may negatively impact the recovery and comfort of individual patients. In effect, this obligates the patient to serve the needs of the healthcare system rather than the institution serving the needs of the patient. Instead, decisions should be made on a case by case basis, always assuming that risk to staff can be sufficiently mitigated (e.g., through provision of appropriately fitted N-95 respirator) to allow comfort and perhaps curative care to individual patients.

Appendix 2: 8 Elements for a Crisis Communication Team to Address

1. Identify the crisis (or crises):

During the COVID-19 pandemic there may be several crises that your facility will face concurrently, such as a severe staff shortage and shortage or absence of essential PPE. Identifying and prioritizing needs can help you plan next steps.

2. Identify the communicators:

Because crisis communication of health information must be complete, transparent, and compliant with HIPAA privacy and security requirements, planning is best handled by a team. The team will vary depending on the setting; for example, in a nursing home a team may include medical (e.g., medical director, director of nursing), administrative (e.g., nursing home administrator), and legal and communications representatives. However, to ensure consistency across communications, one individual should coordinate the communication for the team whenever possible.

3. Identify stakeholders:

Your stakeholders may include staff; residents and their loved ones; state and local government entities, such as the health department or survey agency; and local healthcare providers and coalitions. They can also change depending on the crisis, so taking a moment to define who they are will allow you to develop a strategy and tailor your message. Sometimes, you may be forced to prioritize the needs of some stakeholders over others.

For example, there may be a lack of PPE in a COVID-19 naïve nursing home in a state that has mandated every nursing home admit COVID-19 positive individuals. By taking these patients, there is a risk of exposing an unprepared, naïve facility to COVID-19. The team will need to effectively express its facility's limitations to its acute care partners as soon as possible and work with them and health officials to identify an alternative.

In this instance, the immediate stakeholders are your organization's acute hospital referral partners. Other stakeholders you could consider prioritizing include the health department, state survey agency, emergency management agency, and the long-term care Ombudsman partners in your area. You will need to effectively communicate to them:

- Your facility's lack of exposure to COVID-19

- Your PPE counts

- Why you should not be forced to take a resident

Your assessment should be transparent and coincide with your data. Communicating these facts effectively will show why it would be mutually beneficial to avoid exposing your vulnerable population to this disease.

4. Create a hierarchy for sharing information on the crisis:

The crisis team should be known to the entire organization. Inquiries should be delivered to the crisis team and answered by their designated person. This will decrease the chance of inconsistent communications to stakeholders. All answers should also be aligned with policies and procedures.

5. Assign people to create fact sheets:

During a crisis your organization will be inundated with questions. Many of them will be predictable and others may be unpredicted but common. Your organization should publish and continually update a page of frequently asked questions with clear answers pertaining to the crisis. You may have separate documents depending on the intended audience—clinicians, staff or residents/families. These documents can be developed by experts identified by your crisis team. AMDA has several resources members can use.

6. Create a repository of best practices:

When dealing with a rapidly evolving crisis such as the COVID-19 pandemic, it is a good idea to develop a repository of best practices. These best practices should be made readily available to leaders in your organization, and the date (or revision date) should be bolded at the top. It should also be continually evolving and updated to conform to CDC and governmental regulations. Assign someone on your crisis team to keep an eye out for the latest guidance from the government. This guidance should be consistent with your organization's policies and procedures. In some cases, your best practices may precede and even influence your facilities' policies and procedures.

7. Identify potential risks:

The communications team should think about potential risks to the organization that your communication plan can expose and how they will respond to missteps. For instance, in an effort to be transparent, you accidentally disclose protected health information under the HIPAA Privacy Rule. What must your team do? How do you mitigate reputational injury related to having to report your COVID-19 data to the state for publication?

8. Create guidelines specific to broadcast, print and social media:

This can be an important tool to promote transparency and highlight what your organization is doing to combat COVID-19. Things like listing your visitation policies and explaining why they are in place, sharing ways that your staff is keeping residents engaged and active during

isolation, and encouraging family members and friends to donate needed items and call/video conference with their loved ones in the nursing home can lead to positive stories in the media.

You may also want to publish certain stories internally. Many of your own healthcare providers will be watching what you do during this crisis. Many will be nervous, and some may be ready to quit. Consider interviewing staff in your facility who have recovered from COVID-19 and returned to work. This will abate some of the fears your team has. Be ready to listen to them and respond accordingly. Weekly staff huddles can help with this.

9. **Align communications to meet federal civil rights requirements.**

Federal civil rights laws, such as Section 504 of the Rehabilitation Act of 1973 and Section 1557 of the Affordable Care Act, require covered entities to ensure effective communication and provide appropriate auxiliary aids and services to persons with disabilities unless doing so would fundamentally alter the nature of the program, or constitute undue financial and administrative burdens. Examples of these actions can include the provision of qualified interpreters, information in alternate formats, accessible electronic and information technology, and access to designated support persons for individuals with disabilities to assist in their communication and care.

Federal civil rights laws, including Title VI of the Civil Rights Act of 1964 and Section 1557 of the Patient Protection and Affordable Care Act, also require recipients of federal financial assistance to take reasonable steps to provide meaningful access to individuals with limited English proficiency eligible to be served or likely to be encountered in its programs and activities, which may involve providing language assistance services. Examples of reasonable steps may include providing written or oral language assistance services, such as written translations of documents, or oral language assistance from a qualified interpreter, either in-person or using remote communication technology.

Finally, as a condition of receiving federal disaster assistance, section 308 of the Stafford Act also prohibits discrimination on the basis of race, color, religion, nationality, sex, age, disability, English proficiency, or economic status.

Appendix 3: Nursing Home Incident Command System: Orientation to Development and Implementation

Nursing homes (NHs) provide essential services that must be guarded at all times, including when an emergency incident occurs that threatens the capability of a NH to safely care for its residents, staff, and visitors; or conduct its operations in a way that maintains business viability and continuity of operations.

The Incident Command System (ICS) provides a proven, practical road map to disaster management that is an integral part of the Federal Emergency Management Agency's National Incident Management System (NIMS). ICS has been embraced for incident management throughout the public and private sectors.

Nursing Home ICS, or NHICS, provides standardization that can improve the ability of an organization to successfully respond to a disaster by managing emergencies/disasters (incidents) that require a coordinated response beyond typical day-to-day challenges. Nursing homes have adapted ICS to fit their specific needs.

The NHICS doesn't replace a facility's emergency preparedness program—rather, it provides a flexible structure for adapting and implementing the emergency program plan under the unique, and uniquely challenging, circumstances created by the COVID-19 pandemic. As such, it may better position NHs to quickly identify and adopt operational shifts aimed at mitigating risks that might otherwise force a facility to move to contingency or even crisis standards of care.

The following sections have been adapted from the [NHICS Guidebook (2017).](#) Interested readers are strongly encouraged to access the Guidebook for additional details.

NHICS Functions and the Incident Management Team

NHICS recognizes that the following essential responsibilities must be met to successfully manage an incident:

- Command: People that LEAD/MANAGE all the activities necessary to support incident goals and objectives
- Operations: People that DO stuff to support incident goals and objectives;
- Logistics: People that GET stuff to support incident goals and objectives;
- Planning and Intelligence: People that COLLECT RELEVANT INFORMATION, ANALYZE and PLAN to support incident goals and objectives; and
- Finance and Administration: People that take care of FINANCIAL, ADMINISTRATIVE, AND CLERICAL SUPPORT for incident goals and objectives.

While all five functions within NHICS – Command, Operations, Planning, Logistics, and Finance and Administration – must be covered for each incident, the number of people required to fulfill those roles (i.e., the size of the IMT) may range from one person (the "Incident Commander") to many people in a large disaster. The type of incident, magnitude of impact to the facility or the larger community, and many other factors will dictate the size of the IMT. A determining factor is called span-of-control, i.e., the number of people that can effectively manage the incident is determined by the size and complexity of the incident.

Pages 3–10 of the NHICS Guidebook outline specific roles and responsibilities commonly associated with each of the five functions, recommendations for assembling the IMT, and an IMT organizational chart. NHICS has also published an Infectious Disease Incident Response Guide that outlines many of the immediate and longer-term actions that specific members of the IMT may take to support an effective response effort.

Incident Action Planning (IAP)

The IAP is a core concept of NHICS and must occur regardless of incident size or complexity. IAP involves the following six essential steps:
1. Understanding the nursing home's policy and direction: The IMT should understand the NH's mission, EOP, policies, and procedures.
2. Assessing the situation: Situational intelligence is the core to developing appropriate response actions and providing critical impact assessments that help anticipate the scope of the event.
3. Establishing incident objectives using **Management by Objectives**: The IC sets the overall command objectives for the response.
4. Determining appropriate strategies to achieve the objectives: Once the IC has identified the command objectives, the section chiefs determine the appropriate response strategies.
5. Giving tactical direction and ensuring that it is followed by facility staff and others.
6. Providing necessary back-up: Support is needed to meet the objectives.

PALTC facilities can use the NHICS Form 200: Incident Action Plan Quick Start to begin developing and documenting their plans.

Internal Communications

Clear lines of internal communication are critical to maintaining situational awareness across the IMT and shaping incident response actions. Regular standing meetings, which may be held in-person or virtually, should include the incident command and essential members of the IMT

(e.g., section chiefs, nursing home administrator, director of nursing). Topics to cover in the context of a COVID-19-precipitated response may include:

1. Current summary of residents and staff, including
   a. Number with confirmed COVID-19 (residents, staff),
   b. Number with suspected COVID-19 (residents, staff),
   c. Number of being treated in-house (residents),
   d. Number of new admissions, transfers, and returns (overall and by COVID-19 status) (residents),
   e. Number on transmission-based precautions (residents), and
   f. Number of staff excluded from work and estimated time until return (staff).
2. Current PPE inventories and burn rates for critical supplies, including gowns gloves, surgical masks, N95 masks, reusable shields, disposable shields, booties, etc.
3. Anticipated or actual resource scarcity and potential response strategies, including conservation, substitution, adaption, reuse, and reallocation.
   a. At minimum, this discussion should cover the following critical categories: PPE, medications/pharmaceutical supplies, COVID-19 testing supplies, and ventilators (as relevant).
4. Updates and recommendations from the medical director and infection preventionist, including any scheduled COVID-19 infectious disease training planned for facility staff.
5. Updates and recommendations from other key command function leads, including those responsible for facility operations, external communications and public relations, resident services, and finance and administration.

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Appendix 4: Resident Preferences during COVID-19 (abbreviated service plan form)

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Resident Name:_____ Apt/Rm #: _____

Dining:

_____ I like music playing while I eat in my room

_____ I watch television while I eat in my room

_____I like to call/video chat with a family member or friend while I eat in my room

Physical activities I like to do in my room with help from staff:

_____Stretching exercises

_____Dance to music

_____Sit-to-stand exercises at my counter or safety railing

_____Lift weights

_____Range of motion exercises

_____Other: _____

Ways I can connect with my friends & family:

_____Telephone

_____Laptop/iPad/Smartphone

    I use this app: Zoom   Skype   FaceTime

_____Other: _____

I need assistance to connect with my friends & family:

Yes   _____No_____

The best times to have assistance are:

When I start to feel bored, I like to:

_____Draw or color; make cards for friends and family

_____Knit/crochet

_____Read or listen to audio books

_____Watch television
_____Use computer to play games / video chat / take virtual tours / send emails
_____Other: _____

Supplies that I need to do activities in my room:_____

_____

If I seem anxious, you can help me by: _____

_____

I like to talk about: _____

_____