COVID-19 Weekly Industry Updates

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McKnight's SENIOR LIVING
News, perspective and analysis

COVID-19 Requires 'Significant Adjustments' to Operating Model, Capital Senior Living Says

Written by: Lois A. Bowers

4/1/2020

Capital Senior Living has made "significant adjustments" to its operating model in response to the COVID-19 pandemic, Chief Operating Officer Brandon Ribar said Tuesday on the company's fourth-quarter and full-year 2019 earnings call.

One or more residents in three of the company's 125 senior living communities have tested positive for COVID-19, he noted.

The company conducts training on infectious disease protocols and safeguards throughout the year to limit the flu and other contagions, Ribar said. And since the coronavirus, he added, Capital has implemented all COVID-19-related recommendations from the government, including the screening of anyone who enters a community.

"In each community, we have worked closely with local health departments and state regulatory agencies and received feedback that all appropriate protocols are in place," Ribar said. "We continue to monitor and support

all of our communities on a real-time basis and implement all appropriate response protocols as necessary with changes in the local market or within our own communities."

Chief Financial Officer Carey Hendrickson said it's too soon to predict the effect the disease had on first-quarter 2020 numbers. "In March and as we move forward, we expect to experience increases in labor costs due to the need to supplement our staff with premium paid labor, and we'll have increased costs related to medical supplies," he said.

To offset COVID-related expenses, Hendrickson said, Capital has reduced spending on non-essential supplies, travel costs and all other discretionary items. "And we've reduced our capital spending to only the most critical projects," he added.

On Monday, the company's board of directors approved a temporary suspension of equity awards for directors and officers.

Net operating income increased in January compared with December, and February NOI improved over January, Hendrickson said. "Our occupied units in January and February were stable with where we ended December and moving into March, prior to the COVID-19 outbreak in the U.S., were trending positively," he said.

Now, President and CEO Kimberly Lody said, the company is seeing fewer move-outs than typical "because people are choosing to stay in place. …They believe that our communities are a great option for them and a good place for them to continue to stay versus going to any other environment in the community."

Move-ins have slowed but are continuing, she said. Virtual tours are increasing, Ribar noted.

"People in every market where our communities are operating continue to seek services," Lody said. "It's at a lower volume than certainly we saw at the beginning of the quarter, but it's a need-based business in a lot of cases, and people do continue to seek out those services."

Capital is being "very selective" with prospective residents, the CEO said. "There are strict protocols in place, and those new residents also must be willing and able to self-quarantine for 14 days upon moving into one of our communities," she said.

One thing the company doesn't plan to do is offer discounting or concessions to try to entice prospective residents, Lody said. Capital reduced the level of concessions it offered by approximately 60% year-over-year from 2018 through 2019, she noted, adding that the use of discounting and concessions "had gotten quite high in 2018."

"In this environment, I don't think that reigniting the discounts and the concessions is the right strategy," Lody said. "I think people are — if they have a need, they are continuing to explore that need and come into senior living. If it's not such an immediate need, we might see them waiting a little bit longer, but a discount or additional financial incentives to them probably are not going to encourage them to move in, in the current environment, if they're not comfortable doing so."

Occupancy at 43 communities is at least 90%, and it is less than 70% at 19 communities, Ribar said.

The company's financial and legal teams are reviewing the Coronavirus Aid, Relief, and Economic Security Act, or CARES Act, the CEO said.

"We believe that there are several items that can be helpful to us," including the deferral of social security taxes, mortgage debt forgiveness programs and access to capital to help with incremental operational expenses, she said.

"We're working through those and exactly what can be applicable to our business and what we'll be able to utilize," Lody said. "We intend to utilize as many of the provisions of that act as possible, and we'll know more in the coming days."

The pandemic hit as Capital completed what Lody called "a reset year" for which it reported a net loss of $36 million. Revenue, however, stabilized in the fourth quarter, at $108.7 million, an amount consistent with the revenue contributions for like communities in the third quarter 2019.

"It is clear that the work we did during 2019 to strengthen the operational foundation of the company prepared our business for the current environment," the CEO said.

"While the impact of COVID-19 is difficult to predict, we're encouraged to see the financial improvement during the first several weeks of 2020," Lody said. "We still have a lot of work to do, and I'm confident that we will navigate through the current environment with excellence and continue our path of incremental improvement once the overall environment stabilizes."

McKnight's SENIOR LIVING
News, perspective and analysis

Provider Groups Dispute Judge's Claim that Senior Living is Unsafe During Pandemic

Written by: Lois A. Bowers

3/31/2020

A provider organization in Texas is educating residents, families and the general public about the relative safety of senior living communities and nursing homes during the COVID-19 pandemic after a public official recommended people move their loved ones out of such settings.

Dallas County Judge Clay Jenkins made the remark Sunday after several cases of the disease, including one death, have been reported among residents and staff of senior living and continuing care retirement communities and skilled nursing facilities.

"What I am saying is, if you bring your loved one home, it's safer than leaving them in the nursing home, if you can," Jenkins said, according to the Dallas Morning News. The judge said he moved his mother from her independent living community approximately three weeks ago and she now is living in his home, the media outlet reported.

LeadingAge Texas President and CEO George Linial, CAE, told *McKnight's Senior Living* that he was surprised by the judge's words. The organization is advising residents to stay put.

"Our communities are laser-focused on ensuring the safety and well-being of their residents and their employees," Linial said. "Abruptly removing a family member can have a negative result. People considering moving their loved ones home should understand that for some residents, the trauma of relocating, lack of available services, clinical support and infection control measures can pose a much greater risk."

Families who move their loved ones home to live with them also may need to screen home health workers to determine whether they have been exposed to COVID-19 elsewhere, Linial said. "Then let's say that they spend a week or two away and then the family realizes they can't take care of them, then getting them back into the facility is another issue in itself, and those residents have to be quarantined and a whole process is put in place that makes other residents at risk," he added.

Linial said LeadingAge Texas appreciates some of the points made by the judge in an order issued Sunday for long-term care facilities. That order prohibits nonessential visitors unless they are providing critical assistance or visiting a resident at the end of life and specifies what communities must do to notify others when a case of COVID-19 is discovered.

The National Center for Assisted Living said that although families want to do what is best for their loved ones, moving someone out of an assisted living community or nursing home "could really be doing your loved one more harm than good" due to the risk of the virus in the greater community and the fact that younger individuals do not always show symptoms.

"For assisted living residents specifically, while the [Centers for Disease Control and Prevention] does not recommend moving residents, that's something that family members need to work out with their loved one's community. Every assisted living resident is different, so they may be a bit more independent than nursing home residents," NCAL said in a statement to *McKnight's Senior Living*. "But usually, if they came to assisted living, it's because they had needs that could not be met in the home. Also, for assisted living residents living with dementia, taking them out of their routine is very disruptive to their health and well-being."

NCAL was one of 34 associations and long-term care providers collaborating with the Alzheimer's Association on guidance for assisted living and memory care communities, nursing homes and other providers amid the coronavirus crisis. That guidance was released Monday.

Skilled Nursing News

As Nursing Homes Look to Separate COVID-19 Residents, Rural Providers Face Tough Choices

Written by: Maggie Flynn

4/1/2020

As hospitals try to cope with a surge of COVID-19 patients in need of acute care, skilled nursing facilities have moved to make preparations to take in overflow capacity from the health systems and acute care facilities.

In addition, states have begun calling on nursing home companies to create dedicated buildings exclusively for residents with COVID-19, with the goal of safely caring for the infected — and preventing the disease's spread to others.

But the near-universal challenges of staffing and maintaining a supply of personal protective equipment (PPE) are heightened for SNFs in rural areas, and the difficulties posed by distance grow even greater during a pandemic of infectious disease.

"Rural SNFs face their own challenges, and challenges exacerbated by their location — that is no different in the case of COVID-19," Erin Shvetzoff Hennessey, CEO of the Minneapolis-based operating and consulting firm Health Dimensions Group, told Skilled Nursing News in a March 25 e-mail. "The major issue right now for rural SNFs is ensuring they keep their workforce healthy as they do not have the labor pool that other communities benefit from. There has been a constant focus on recruiting, retaining, and educating staff."

Preparations the same — mostly

The basics of preparing a SNF for COVID-19 are the same whether a given facility is in an urban or rural location, Brandon Farmer, the CEO and president of the Alabama Nursing Home Association (ANHA), told SNN.

"Our rural facilities have been preparing, from a protocol and policy standpoint, just the same as the urban facilities have," he said in a March 31 interview. "They've been preparing utilization of the PPE, and have restricted if not almost completely limited all visitation into the building, screening employees as they come in, taking their temperature with each shift. Those protective and preventive measures are in place across the board, whether that's rural or urban."

In Alabama, rural facilities face a unique challenge in that they frequently lack a specific hospital in their county or city, making them "the core of the health care continuum there," Farmer added.

That means coordinating with regional hospitals on how to handle patients who are positive for COVID-19, as well as how to transport them and when that is appropriate. At the beginning of the outbreak, rural SNFs were seeing less COVID-19 patients, but that has begun to change in recent days, Farmer noted.

The ANHA is working with the state Department of Public Health and the hospital association to identify regional areas of greatest need where hospitals might reach capacity quickly, he told SNN. That should help pinpoint places where ANHA's SNFs can develop isolated wings or set up facilities dedicated specifically to COVID-19 patients.

"There are some regulatory challenges that have to be addressed, and some licensing challenges that have to be addressed in many capacities, so we're working through those and trying to be a part of that solution," Farmer said.

CMS announced an array of waivers on the weekend of March 28 designed to make it as easy as possible to move patients between health care settings and ease hospital capacity, specifically waiving requirements for transfers between long-term care facilities to make it as easy as possible for providers to keep COVID-19 patients away from those who aren't infected.

Some of those waivers will likely make things easier; one example that's under consideration in Alabama is reopening a closed assisted living facility that's in good condition and could house residents, Farmer said.

In a followup e-mail, Farmer noted that some of the specific federal waivers under consideration include the physical environment waiver 42 CFR 483.90 and the "under arrangements" provision for transferring COVID-19 patients to alternate care sites while still receiving reimbursements.

In terms of state-level exceptions, waivers for licensing, certain transfer and discharge requirements, the timeframe for assessments, and pharmacy and physical plant requirements are all under consideration.

The ANHA is the state affiliate of the national nursing home trade group the American Health Care Association, which represents more than 14,000 SNFs and assisted living communities.

AHCA has been issuing guidance on the admission of patients, most recently revising its advice to reflect new findings from the Centers for Disease Control and Prevention (CDC) that illustrated how nursing home residents without any symptoms can still play a major role in spreading COVID-19. Under AHCA's new guidance, SNFs should assume that all new patients without a negative test for the disease are, in fact, positive.

That can exacerbate another challenge for rural SNFs: the nature of the building itself. Smaller physical plants pose difficulties for cohorting patients coming back from the hospital, Mark McKenzie, the CEO of the Fort Worth, Texas-based Focused Post Acute Partners, told SNN in a March 27 interview.

As a result, it's drawing on guidance from the CDC, the Centers for Medicare & Medicaid Services (CMS), and AHCA to develop cohorting plans, he said.

"As we've talked to some of our hospitals, we have a handful of buildings that, because of the types of patients that we have, it would be difficult for us — even if one of our own patients went to the hospital and somehow got [COVID-19], it would be difficult," he said. "I'm talking about a couple of our buildings that are smaller in nature, but also happen to have a cognitively impaired unit … we are really working as an organization, and across the system, regardless of a certain industry, on how to manage those particular patients."

For many rural SNF providers, occupancy has been a challenge — which might actually be of help in the case of COVID-19, since it translates to open beds for potential hospital overflow, Hennessey told SNN in the March 25 message. That's harder to do in a community that is already operating near full occupancy, she noted.

While the bed capacity for a rural SNF is less likely to be an issue, and they're more likely to be able to open wings or repurpose entire buildings, any residents that needed to be moved would have to go to the closest SNF, which could be several miles away, Hennessey said in a March 31 message.

"This would only be a last resort if beds are needed in the continuum and to relieve hospital pressure, or to isolate COVID-19 patients in one SNF," she wrote. "Normally, family visitation is a huge barrier to moves, but right now we are not allowing visitors so this may be an easier conversation than it would be during more 'normal' times."

Navigating supply challenges

The shortage of PPE has loomed across the health care continuum, with harrowing stories emerging across the country of hospital doctors and nurses rationing or reusing equipment.

The nursing home sector hasn't been immune either; in mid-March, AHCA held a call warning that masks and gowns were running short, with supplies slated to run out in a matter of weeks.

In Alabama, the shortage is more forward-looking, rather than occurring in buildings today, according to Farmer. That said, the situation can vary from building to building. If a facility has had an exposure, then it has to be "aggressively" making use of PPE — but not all buildings have had this happen.

"It's the anticipation of the fact that we know that those products are going to be harder to come by as we move forward, and so you're going to be running out of them," he said. "That's what the preparation is for."

For Focused Post Acute Partners, it was fortunate in that its primary PPE supplier was able to give them some warning of a supply chain crunch before the COVID-19 outbreak hit the U.S. in a major way. From December 2019 to the end of January, Focused Post Acute was able to secure its usual orders plus an additional 50%. Then it returned to normal levels, McKenzie explained.

By picking supplies they would not normally have purchased, Focused Post Acute was able to build a limited stockpile, though McKenzie noted that there were indeed limits.

"They did a good job of managing — not allowing us to be, as a business partner, to be greedy or over-purchase," he said.

In the meantime, the operator has been following CMS and CDC guidelines around the allocation of PPE, constantly reviewing the guidelines to make sure that it is "keeping within the loosened expectations, but still being practical," McKenzie said.

In addition, Focused Post Acute has been keeping a portion of supplies set aside in the event admitting a patient that's either COVID-19-positive, or who develops symptoms after admission.

One step that helped was a focus on education of staff around hygiene practices, which was happening as standard procedure because of the start of flu season, McKenzie noted. That meant when COVID-19 began to gather momentum, there was a foundation on which to build education for staff members.

PPE orders have generally been permitted using historical trends, and for some communities, that results in a very small allocation, Hennessey noted in the March 25 e-mail. Though Health Dimensions Group's communities — which include SNFs and assisted living facilities — have access to procurement through various sources, rural SNFs might have a more difficult time getting an increase in PPE allocations or having the funds necessary to stock up, she added.

"In smaller communities, small fluctuations in census have a large impact financially, and the delay of non-essential surgeries will impact them," Hennessey said. "The overarching concern in light of COVID-19 is the financial strength of rural communities to withstand an operational pressure like a pandemic."

Skilled Nursing News

Skilled Nursing Telehealth Adoption Not Without Challenges — But COVID-19 Changes Likely Here to Stay

Written by: Alex Spanko

3/31/2020

About a month after COVID-19 first arrived on America's radar, the federal government continues to tear down the dense web of regulations surrounding all aspects of the health care continuum in an attempt to fight back against the coronavirus pandemic.

As health care providers and officials look to prevent all non-emergency visits to nursing homes, telehealth has formed a key pillar of the regulatory relief efforts in the post-acute and long-term care space. Rules previously considered sacrosanct — from HIPAA requirements that prevented clinicians from providing services over consumer apps like Skype and FaceTime, to the need for in-person consultations before telehealth could be be used as a replacement — disappeared overnight.

Just this week, Centers for Medicare & Medicaid Services (CMS) administrator Seema Verma announced yet another round of telehealth expansions, including the approval of virtual visits for nursing facility and discharge visits, as well as coverage for remote patient monitoring.

That latter move, according to AMDA, the Society for Post-Acute and Long-Term Care Medicine, represented the completion of the provider group's goal of "essentially eliminating all barriers and adding services in other sites of care to the telehealth list."

But that doesn't mean the road to telehealth adoption has been smooth, especially in the early days of the crisis. Staff buy-in has always been an issue when rolling out new telehealth programs, even in normal times — and unlike in many other care settings, nursing home residents' unique set of comorbidities can make virtual communication difficult for patient and provider alike.

SNN called Dr. Grace Terrell, CEO of the skilled nursing-focused physician group Eventus WholeHealth, to learn how her company has been rolling out telehealth programs throughout the 500 facilities where the North Carolina-based company provides care.

Though Eventus and its partners have run into some growing pains, Terrell shared stories of telehealth success in the early days of this crisis. And Terrell also predicted that the COVID-19 pandemic — which she described as "the largest unplanned experiment in history at so many levels in health care" — will bring about permanent change in the industry.

"I don't think you're going to be able to put the toothpaste back in the tube," Terrell said. "We're not going to go back; things will change."

Please note that SNN spoke with Terrell on Friday, March 27; this interview thus reflects the situation at that time.

What are you seeing on the ground right now?

The skilled nursing industry is really quite diverse with respect to how it's governed, and who's making decisions. We, Eventus, are in 500 facilities in five states, and have a little over 200 providers providing services. Some of those have a corporate structure with governance at the top, and some of them are little mom-and-pop places. As a result of that, it's not easy, per se, to basically say that there's going to be one approach to how we're going to do things.

We have to really adapt to our partners and customers and say: "What will be the most useful way of addressing what the issues are?"

We had planned for a long time — it was part of our strategy, a strategic action we had already planned on this year — to have telemedicine. We didn't know we were going to put it in place in one week, because we had a larger strategic plan. But what we've tried to do is reach out to all of our facilities and say: "What is the way that we can do this that will be most useful for you all?"

Before there was even a declaration at the national level, we sent out to all of our skilled nursing facility partners some information that said that we would have — for every one of our providers that go to the building — they would attest every morning with a document that they had taken their temperature, that they didn't have any symptoms, and that they had not traveled into the areas at the time that were considered high-risk, and they've not been exposed to anybody with COVID-19. And we're still doing that.

So that was the first thing we did, which is to say: "We take this seriously. We're going to work with you all. And then we're going to also try to create strategies for reducing the number of individuals that are in the building, and how we actually actually provide services" — hence, telemedicine, reduction in some of the services that

we've provided before, such as nail care, for example, in the short run. Any screening exams that were occurring, for our vision care, is not appropriate care during this situation and we've stopped it. So that was reassuring.

We've had some facilities that, interestingly, initially did not want any of our mental health providers or psychotherapy in the facility. So we were working on some telehealth strategies with them, and then they've come right back and said, "Oh, no, that was a huge mistake. We're having all sorts of anxiety and we need you guys." And so we've worked with them to do that.

Most of the SNFs, at least at this point, have had personal protective equipment — but not all of them. So we've come up with some creative ways of having our PPE in the short run, and then we have what we believe is going to be a larger national supply coming in next week.

So we've had to be real partners. But it really has been at the level of being able to be adaptive on the ground and partner with them in ways that we can just solve whatever makes sense. We've had some — without naming the facilities — we've had some situations recently where their non-Eventus medical directors have just quit in the midst of all this. So we've been there to step in and be able to provide some of those services.

Like everybody else, we're taking it day to day.

Tell me about the telehealth implementation. Are your partners really embracing it? Has the transition been smooth? Are there already interventions being conducted on the ground?

We take — even though it's been within a week — a fairly deliberate approach, because our behavioral therapists were some of the first of our physicians to [indicate] they were wanting to decrease the number of visits. We trained them, we created documents that would train our skilled nursing facility administration and nursing staff with what the technology would do and how to use it. And then we rolled it out in some places that wanted it to begin with, and we're going to … offer it everywhere.

We've learned along the way. One of the biggest issues for telemedicine that's happening in the community: You typically may have somebody that's fairly savvy in the community setting and can have an interaction with a clinician face-to-face without any trouble. But you know and I know that the individuals that are in skilled nursing facilities quite often have all sorts of disabilities, and it really requires someone at the field facility to be there to help with the technology — to make sure that it's not just the patient and the clinician interacting, but that the technology is set up and done in an appropriate way.

So that puts strain on the part of the nursing staff and the facilities. In one strategic approach we have, we can have one of our medical assistants go into the building and provide telehealth services for all of our clinicians — whether it's a primary care clinician or a psych med or behavioral therapist — and that limits the number of people in the building, and actually frees up the nursing staff at the SNF to not have to be involved with it.

But some of them haven't wanted that — they don't want anybody in the building that doesn't need to be there. So in that situation, if you're going to use telehealth, you're going to have to have the resources on the other side to host it, if you will.

We're still learning. We're very early in the process, but there is significant types of work that may need to be done — because, as this situation changes in real time, they're going to be short-staffed themselves.

Are you seeing staffing shortages at these facilities? How is morale?

We're not hearing of staffing shortages much yet in our areas. We're not in some of the high-incidence areas like New York or California or Washington right now. There is — I believe on the part of all of the health care industry — a lot of anxiety about what's getting ready to hit us, because there has been a reduction in admissions to many of the skilled facilities in the short run as a result of a reduction in elective procedures in the hospital. I think for a little while, we're in the calm before the storm. I think that that may well get worse.

We've had one of our providers that was COVID-positive. We immediately quarantined her; we informed the facility. There's been no cases in those facilities that have occurred. But we worked and partnered with them with respect to making sure that all those residents were being monitored on a regular basis.

When things like that happen — and it's going to be more of that — there's just going to be a lot of fear and a lot of anxiety. So what we're trying to do is be the best partners we can to our SNF partners.

How do you think this is going to permanently change the post acute and long term care landscape? Obviously in the matter of two weeks, CMS has erased a lot of regulations and a lot of long-standing rules that had been in place for decades in some cases.

I don't think you're going to be able to put the toothpaste back in the tube. We're not going to go back; things will change. We've got the largest unplanned experiment in history at so many levels in health care — around the world in so many different ways. There will be many things that we will learn about it.

HIPAA is based on things that still need to be true, which is respect for privacy, respect for the security of patient information. But one of the things that that particular regulation has always done — possibly it was a barrier to certain types of technology innovation.

So now that we have that, in the short run, stopped, then there will be the opportunity to see the results of the lack of regulation, and there'll be innovation that comes out of it, I believe, on the technology side. One of the things that is true with clinicians in the community that have not had the experience of telemedicine — I'm hearing from many of my colleagues they never want to go back. They're enjoying it.

I'm a clinician. I'm an internist, and in the past, I did some work for Teladoc, including about 5,000 telemedicine visits; I've written a white paper on telemedicine in the past. I think that this is an industry that was ready to be transformative, but we had these barriers in place — and now that they've been removed, there will be the opportunity to learn from that, and then you'll see some real redesign of the way a lot of care is provided.

This interview has been condensed and edited for clarity.