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McKnight's SENIOR LIVING
News, perspective and analysis

Rapid Testing is the Answer

Testing is the only way that we can find out the infection rate of a building that is especially important when it comes to protecting our seniors against COVID-19. This virus is prevalent and extremely commutable, and testing efforts need to remain strong until there is a viable vaccination approved.

Written by: Lynn Katzmann, Ph.D.

7/14/2020

For those with limited time or patience, here is the punchline: Rapid, widespread testing is the only way to outrun COVID-19 short of an effective, widely distributed vaccine.

COVID-19 has been clouded in a deep fog since it was first identified in Wuhan, China, in December. What we knew almost immediately was that it was highly contagious and could be lethal, particularly for individuals with underlying health conditions, most notably hypertension, heart disease and diabetes.

COVID-19 is a novel virus, meaning it is a virus we have not had the pleasure of experiencing before. Because it severely affects the respiratory system, public health officials early on issued guidelines consistent with those that worked for SARS in 2003. In the 2003 SARS epidemic, the disease was spread only by individuals who were symptomatic. The epidemic was controlled by symptom-based detection and testing that, in turn, provided a guide to isolation and quarantine.

And so, initially, guidance for COVID-19 seemed clear: test those who were symptomatic, conduct contact tracing, and isolate or quarantine exposed individuals to stop the spread of the disease. But according to the New England Journal of Medicine, we now know that COVID-19 is a disease of the upper respiratory system rather than the lower, where the SARS virus thrived. It is now believed that viral shedding occurs more easily and earlier from the upper respiratory tract. This may explain, at least in part, why COVID-19 is more readily spread asymptomatically.

It also now is clear that the screening protocols put in place at healthcare facilities were necessary but insufficient to stop the spread of the virus. They were designed to identify those with known symptoms such as fever. People

were screened at the door and halted from entering if symptomatic. This was inadequate given that the spread of COVID-19 is both insidious and invisible.

Testing is the only way to identify asymptomatic carriers.

But not all testing is the same.

Two very different types of tests

There are essentially two types of tests that do very different things. The first are those that detect the active presence of the virus. The second are those that detect antibodies produced in response to the infection. The first group, which detects the active virus, has two distinct test types: 1) RT-PCR (PCR), commonly known as the swab or sputum tests, and 2) isothermal nucleic acid amplification tests.

The PCR tests currently are most prevalent and involve taking a sample from an individual and sending it to a lab for processing. Depending on the lab, the results generally are promised within 24 to 48 hours. Unfortunately, given the large number of tests and the small number of labs, wait times for results are often much longer, particularly now given the current surge in cases.

An alternate test for active COVID-19 typically is called the rapid test. Although there are several varieties of these tests, the results usually are available in either minutes or hours. The most well-known of these, Abbot Diagnostics ID NOW, was given an emergency use authorization, or EUA, from the FDA on March 27. The Abbot Diagnostics tests have come under scrutiny lately, however, due to a high number of false positive and false negative results. There are now 4 EUA-approved tests of this type that may be performed outside of a moderate or high complexity lab.

The second group of tests detects antibodies to COVID-19. These tests provide a snapshot that shows how many people have had the disease, including those who were/are symptomatic. These tests also are known as serology tests, and as of July 12, 28 laboratories had received their EUA from the FDA. The tests look for two different antibodies, IgM and IgG, which are believed to be generally detectable in the blood several days after infection. These antibody tests are being used to determine what part of the population already has contracted the virus and may therefore be immune. Unfortunately, there is no evidence that antibody presence means immunity or if immune, how long that immunity will last.

The Centers for Disease Control and Prevention provides data on the number of laboratories that offer COVID-19 testing. As the data indicate, the number of labs has increased dramatically in the past several months. Unfortunately, even with this ramp-up, we continue to face shortages, particularly for viral tests. In addition, with cases increasing across the nation and demand for testing growing, the processing time has gotten longer, meaning that people with the virus may be in transmitting it while waiting for results.

Together, these two types of tests — viral and antibody — are essential to gain a clear picture of disease spread in the United States.

The front line includes senior living

Early during the crisis, primarily due to short supply, tests were provided first to hospitals and other “front-line” healthcare professionals. Unfortunately, the current definition of front-line healthcare professionals is only now beginning to include senior housing. Unlike hospitals that care for those already sick, we are home to Americans who are both more susceptible to the harsh consequences of this virus and those who, when sick, use most of

the hospital resources. If we want to outrun this virus, then we need to keep these Americans safe and, to the greatest extent possible, COVID-19-free.

The best way to do this is to make sure that everyone coming in contact with these people is disease-free. And the only way to do that without a vaccine is a test to ensure that those in contact do not have the active, communicable virus. The way to do that is to test. And to test everyone who has not recovered from the disease, every day.

I still believe that we are the greatest country, capable of amazing efforts for the public good. We need to put our efforts into rapid testing, make it widely available until a vaccine is ready, and prioritize our greatest and silent generations and their caregivers.

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How We Market CCRC Living in a COVID-19 Hot Spot

The senior living industry is under scrutiny at the moment, especially from those that have considered having a loved one placed in a community for their well-being. One such community is taking a fresh approach to how they look at the benefits of their programs and settings for seniors.

Written by: Eric L. Eichhorst

7/14/2020

Like most of the senior living industry, in early 2020, we didn't fully anticipate the full effect that the coronavirus would deliver, especially here in New Jersey.

The onset of the virus here was fast and devastating. Our community mobilized in early March by limiting visitors and installing hand sanitizers at every turn. Just days later, we supported a state-mandated stay-at-home isolation status, which was in place for nearly 10 weeks.

As I am writing this, our community is still closed to non-residents.

These early steps absolutely reduced the number of diagnosed cases here. Recently, we enjoyed 40 consecutive days with no COVID-19 cases in a community of more than 300 residents and 150 staff members.

My sales and marketing team quickly pivoted from promoting Applewood to prospective residents to an all-hands-on-deck commitment to ensuring that current residents were comfortable at home, with all of their immediate needs met.

We next shifted focus to more than 100 prospective Applewood residents who still were residing in 55+ communities, private homes or apartments.

Admittedly, none of us had been in this dire situation before, and we certainly had no formal guidance on how to initiate contact with prospects successfully during a pandemic. As a team, we collectively agreed to reach out with a single question in mind: How can we help you?

The response was powerful and significant. From needing groceries, prescriptions, gas in the cars and help with banking, we got to work on the phones and in our cars. We grocery shopped for a frightened single woman who was (and still is) stuck in her home with no family. Matt Mazzucca, sales counselor, went to the store with her list and bought the items she needed. Sales professional Mary Somers delivered ready-to-eat meals to several of her clients via a “pop and drop” (pop into their home, drop off food and staying socially distanced).

We’ve helped put our future residents in touch with distant family members, dentists and plumbers. Whatever needed to be done, our sales team has done our best to help.

From a business perspective, we also performed safe and protected on-site home visits with prospective residents. By checking on people’s well-being, we worked to solidify their trust.

Keeping the CCRC lifestyle alive, even in isolation

In April, we sent a direct mail piece to our database regarding our Engaged Living at Home program; it outlined home-based activities designed to support our Engaged Living lifestyle. From fitness tips to a simple healthy recipe, the piece was a personal, colorful, informative “insider” look at Applewood, meant to help keep our community top-of-mind. The mailing included a personal and heartfelt letter from our executive director, encouraging people to stay healthy, positive and engaged.

Applewood Connections, a new pandemic-era publication, is being published by our Engaged Living coordinator, compiling social, club and special event activities along with creative submissions from residents. The result is a fun and uplifting printed newsletter, hand-delivered to each resident.

Our marketing team also shared this newsletter directly with prospects, to make them feel like part of our community and engaged during our prolonged social isolation.

We were delighted to receive responses asking when the next newsletter would be available. During the long and challenging days of April and May, these compliments inspired us to increase the personal attention to future residents even further.

Customized video messaging

We frequently shoot personalized video tours using an industry-specific program to present apartment models and answer buyers’ pointed questions (For example: Can you show how far the walk-in closet is from the bathroom? Or: What exposure does that cottage have?)

Here’s an example of a video I created for a prospect.

Although our website offers several virtual tours and images of our public spaces, some people also want to see the bocce court location and the beautiful views along our lighted walking paths.

In late June, we hosted our first-ever drive-through open house, inviting older adults and their families to see Applewood live — all from the safety of their cars. Along the afternoon tour, guests were treated to delicious dessert specialties provided by our dining services team, received community marketing collateral materials, were given branded hand sanitizer and face masks, and had the opportunity to chat with our sales team live, from a safe distance.

Seniors use time at home to plan their next move

During the second week of March, when New Jersey was on the cusp of implementing a stay-at-home order from the governor, we closed and moved-in six new households. We also have confirmed five new contracts from singles and couples eager to end the isolation in their homes and move to the more protected and service-rich environment of Applewood. These new relationships were established under Applewood's strict community guidelines and precautionary protocols during this global pandemic.

In fact, after the prolonged isolation caused by the coronavirus, we already are seeing robust interest from new customers looking to improve their quality of life in the COVID era and beyond.

Marketing a senior lifestyle of mind, body and spirit

Seniors benefit in mind and body from socialization and being part of a broader community. The pandemic has sent a clear message to many seniors — and their loved ones — whose mental and physical health was jeopardized by lack of access to food, daily necessities, routine healthcare and regular social interaction.

Certainly, times have changed for all of us. But our innate need for the incomparable safety and peace-of-mind of home remains strong and desirable. Although the methods we use to market senior living are different, they never have been more essential to supporting seniors seeking to escape isolation and gain added services and socialization benefits.

Today, our managed care community's doors are open to new faces, old stories and new experiences. We just need to tell the story of Applewood a bit differently.

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HHS Extends Deadline for Assisted Living Operators to Apply for CARES Act Funding

The Department of Health and Human Services on Friday extended until Aug. 3 the deadline for eligible state Medicaid and Children's Health Insurance Program providers, including assisted living operators, to apply for monies from the Coronavirus Aid, Relief, and Economic Security (CARES) Act Provider Relief Fund.

Written by: Lois A. Bowers

7/20/2020

HHS announced June 9 that approximately $15 billion in grants would be distributed to Medicaid and CHIP providers who are experiencing lost revenues or increased expenses due to COVID-19. July 20 was the original deadline to apply.

“The first general distribution of the Provider Relief Fund, $50 billion back in April, made payments to over 1 million providers. Approximately 450,000 of these providers care for Medicaid and CHIP recipients,” Eric D. Hargan, deputy HHS secretary, said in June. The new funds, he said, would be available to the remaining 275,000 providers that care for Medicaid and CHIP recipients but did not receive funds in the general distribution.

“These Medicaid and CHIP providers typically operate on thin margins and often include practitioners like dentists, pediatricians, assisted living facilities, and behavioral health providers like opioid treatment programs,” Hargan said.

Payments to each provider will be at least 2% of reported gross revenue from resident/patient care, according to HHS. The final amount each provider receives will be determined after the data are submitted, including information about the number of Medicaid beneficiaries a provider serves.

To be eligible for the funding, providers must not have received payments from the $50 billion Provider Relief Fund general distribution in April and must have directly billed their state Medicaid program or Medicaid managed care plan for healthcare-related services between Jan. 1, 2018, and May 31, 2020.

HHS has posted a fact sheet here, instructions for the application form here, and answers to frequently asked questions here.

The American Health Care Association / National Center for Assisted Living has posted a tip sheet and step-by-step guide for providers on how to successfully navigate the Provider Relief Fund Payment Portal for non-SNF Medicaid providers.

Forty-eight percent of assisted living communities are Medicaid-certified, and approximately 16.5% of assisted living residents rely on Medicaid to cover their assisted living services, according to NCAL.