EDITORIAL

Playing the Cards We Are Dealt: COVID-19 and Nursing Homes

THE FACTS

We have lived with coronavirus disease 2019 (COVID-19) for several months. We have learned that COVID-19 is remarkably infectious, even when not causing symptoms,[1] that congregate living situations invite rapid spread, and that frail older adults are at the highest risk of death. Nursing home residents have experienced at least one-third of U.S. COVID-19 deaths up to mid-May 2020.[2]

Throughout this pandemic, public policies and clinical practices reflect a balance between dealing with the existing situation and hoping for future vaccines and treatments. Hoped-for solutions are not likely within the coming year,[3] so we must prepare to deal with the situation as it stands—which is, I believe, going to entail widespread COVID-19 infection among residents of nursing homes.

Current efforts to limit the spread of COVID-19 into nursing homes, including banning visits and congregate activities, may delay the onset and slow the spread of outbreaks. However, because nursing home staff generally live in communities with ongoing spread, an infected asymptomatic staff member will eventually infect a resident or a new or returning resident will bring it along. Personal protective equipment, even when available and properly used, is not 100% effective; and residents' behaviors and intimate caregiving cause lapses. Diagnostic testing has substantial false negatives.[4] Eventually, the odds of being infected become stacked in favor of the virus. Even if a person keeps a 1% risk per day, that person has an 84% likelihood of having been infected within 6 months ($1–0.99^{180} = 1–0.164$). In areas with high community COVID-19 infection rates, such as New York, NY, Boston, MA, and Baltimore, MD, virtually all nursing homes have some residents and staff infected and many have had pervasive spread.[5] Eventually, the virus is likely to infect a majority of nursing home staff and residents, and herd immunity would then provide some protection for uninfected persons. Herd immunity may require at least 50% to 66% of the community to have recovered from infection.[6] In short, most people who reside or work in nursing homes seem likely to have COVID-19 infection before an effective vaccine becomes available.

Currently, we do not have effective treatments for COVID-19. Most infected nursing home residents have mild symptoms or none when initially tested, although they may develop symptoms later.[1] Still, nursing home residents often recover without hospitalization.[7] However, among community-dwelling persons 80 years and older currently requiring critical care, only about 15% survive,[8] usually with substantially increased disability. Rates for critically ill nursing home residents are likely to be worse.[9]

THE IMPLICATIONS

These are the cards we have been dealt—the facts as they stand. The situation calls for a perspective rather different from the framing of recent leadership statements and government guidelines, which make broad claims that testing, social distancing, and personal protective equipment will keep people "safe."[2,7] That image is comforting but misleading, because these current actions actually just avoid overwhelming the care system and delay having to take our turns at the roulette wheel of COVID-19. The scorn heaped on nursing homes for their infection and death rates[10] is, for the most part, misplaced. Nearly all nursing homes will have their outbreaks.[5] A universal testing study in Maryland found that most nursing homes already had COVID-19 infections and those with even "one or two" symptomatic cases already had most residents infected.[7]

An honest pragmatism would predict many more deaths from COVID-19. If just one-tenth of the nursing home population dies, this cohort will have about 150,000 deaths.[11] This may prove to be a conservative estimate. That number of deaths is hard to acknowledge, but the facts are implacable.

This pragmatic perspective encourages thoughtfully revising the current restrictions on nursing home residents and visitors. Currently, only persons necessary for tasks arising from personal care needs see residents, and then in masks, hoods, gloves, and gowns (in whatever combination is available). Keeping residents in solitary confinement for months seems cruel to residents, family, and friends. Can we expect residents to give up ever again feeling a human touch, seeing family members, joining in a song, or attending a religious service? In return, that resident could expect to live a little longer before dying of COVID-19 or something else. Many nursing home residents and their families might prefer to take their risks with COVID-19—rather than enduring a barren, but longer, survival. At the least, we should be asking residents and their families for their well-informed preferences before imposing severe isolation measures indefinitely.

DOI: 10.1111/jgs.16658

0002-8614/20/$15.00

Once past its outbreak—with tests confirming that a high proportion of residents and staff had documented illness or have immunity—a "herd immune" nursing home could loosen these restrictions. Experts agree that having had COVID-19 infection yields immunity for at least the near future, and ongoing observation will tell if immunity is incomplete or short lived.[3] A postoutbreak nursing home might review documentation of infection and offer immunity testing, aiming to allow immune persons to visit freely. Otherwise, visitors could be supervised while using personal protective equipment if visiting a nonimmune resident. That home might resume congregate meals, entertainment, and therapies. Some facilities might admit only immune residents and recruit immune staff; and those facilities could test nonimmune residents and staff regularly to detect sporadic cases and institute contact tracing.

THE OPPORTUNITIES

The novel coronavirus has put a spotlight on the inadequate funding and staffing of nursing homes. As we recover, long-term care and its financing should be reimagined and reformed. How many older adults living with which disabilities could live in community settings at a reasonable cost, if sufficient support was available? How many families could support their own, with what community help? When facility-based care is best, what matters most to residents and families? The resident and family should structure their own services where possible. Perhaps, nursing homes and their residents could participate more in their community—schoolchildren could come to play and sing, and community meetings could be held in their facility. Nursing homes should be welcoming, enabling, supportive, and friendly—like a well-functioning family setting. Experts in eldercare should resist allowing the COVID-19 experience to force nursing homes be as sterile, alienating, and impersonal as hospitals often are.

Clinicians serving older adults need to envision a better future, forge a consensus, and speak out on behalf of their patients, their families, and their future older selves.[12] Opportunities will arise to shape the future, including not allowing older people care to be plagued with weak standards and inadequate funding. We should advocate for sustainable financing, more disability-adapted housing, availability of appropriate food, support for family caregiving, decent wages and benefits for paid caregiving, and a much more age-friendly healthcare system.[13] Committed advocates who deserve strong support back each of these aims. The public and our civic leaders need to learn how everyone could count on a reasonably comfortable and meaningful last phase of life. COVID-19 will offer opportunities to build desirable and efficient eldercare arrangements. Without a voice from geriatricians and others who serve older adults, we risk backtracking to grim institutions, inattention to housing and food, and overburdened families. We can make it better, and we should. We can start by pushing for frankness, honesty, and deliberately patient-centered and pragmatic policies.

Joanne Lynn MD, AGSF
Program to Improve Eldercare, Altarum, and Health and Aging Policy Fellow, serving as staff in the office of Rep. Tom Suozzi, Washington, DC, USA

ACKNOWLEDGMENTS

Conflict of Interest: The author has no conflicts of interest to declare.

Author Contributions: The author is responsible for the content.

Sponsor's Role: The author acknowledges the support of the Health and Aging Policy Fellowship that enables engagement in the COVID-19 work. There was no financial sponsor directly supporting this work.

REFERENCES

1. Kimball A, Hatfield KM, Arons M, et al. Asymptomatic and presymptomatic SARS-CoV-2 infections in residents of a long-term care skilled nursing facility — King County, Washington, March 2020. MMWR Morb Mortal Wkly Rep. 2020;69(13):377-381.
2. Yourish K, Lai KKR, Ivory D, Smith M. One-third of all U.S. coronavirus deaths are nursing home residents or workers. *New York Times*. https://www.nytimes.com/interactive/2020/05/09/us/coronavirus-cases-nursing-homes-us.html. Updated May 11, 2020. Accessed May 26, 2020.
3. Fauci A. "COVID-19: safely getting back to work and back to school," hearing of the U.S. Senate Committee on Health, Education, Labor & Pensions, May 12, 2020. https://www.help.senate.gov/hearings/covid-19-safely-getting-back-to-work-and-back-to-school. Accessed May 22, 2020.
4. Wang W, Zu Y, Gao R, et al. Detection of SARS-CoV-2 in different types of clinical specimens. JAMA. 2020;323(18):1843-1844. https://doi.org/10.1001/jama.2020.3786
5. Konetzka T. "Caring for seniors amid the COVID-19 crisis" Senate Special Committee on Aging, May 21, 2020. https://www.aging.senate.gov/hearings/caring-for-seniors-amid-the-covid-19-crisis. Accessed May 22, 2020.
6. Walensky RP, del Rio C. From mitigation to containment of the COVID-19 pandemic: putting the SARS-CoV-2 genie back in the bottle. JAMA. 2020;323(19):1889-1890.
7. Katz M. Keeping nursing home residents and staff safe in the era of COVID-19: a webinar. National Academy of Sciences; 2020. https://www.nationalacademies.org/event/04-22-2020/keeping-nursing-home-residents-and-staff-safe-in-the-era-of-covid-19-a-webinar. Accessed May 22, 2020.
8. Widera E. COVID-19 prognosis information. Geripal. https://www.geripal.org/p/covid-progn.html. Updated April 24, 2020. Accessed May 22, 2020.
9. Ouslander JG. Coronavirus disease19 in geriatrics and long-term care: an update. J Am Geriatr Soc. 2020;68:918-921.
10. Stockman F, Richtel M, Ivory D, Smith M. "They're death pits": virus claims at least 7,000 lives in U.S. nursing homes. *The New York Times*. April 17, 2020. https://www.nytimes.com/2020/04/17/us/coronavirus-nursing-homes.html. Accessed May 22, 2020.
11. National Center for Health Statistics, Centers for Disease Control and Prevention. Nursing home care. In Fastats. https://www.cdc.gov/nchs/fastats/nursing-home-care.htm. Accessed May 22, 2020.
12. Lynn J. The "fierce urgency of now": geriatrics professionals speaking up for older adult care in the United States. J Am Geriatr Soc. 2019;67(10):2001-2003. https://doi.org/10.1111/jgs.16116. Epub 2019 Sep 12.
13. Institute for Healthcare Improvement. What is an age-friendly health system? Institute for Healthcare Improvement. http://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Pages/default.aspx. Accessed May 22, 2020.