hcam
PROMOTING EXCELLENCE IN SENIOR CARE

7413 Westshire Drive
Lansing, Michigan 48917

Phone: (517) 627-1561
Fax: (517) 627-3016
Web: www.hcam.org

COVID Death Reporting by Skilled Nursing Facilities

An Analysis by the Health Care Association of Michigan (HCAM)

From the first Michigan appearance of COVID-19 in early 2020, skilled nursing facilities have been engaged in an outright, full-scale, and unrelenting war with an enemy that displays no mercy to the elderly we serve and has sadly taken the lives of too many of our residents and caregivers. For months, caregivers put their lives and health at risk to protect our residents, even as the fight quickly drained financial resources in the midst of struggles with little to no supplies, inadequate testing, and near daily changes in guidance from various levels of government.

The past two years have been the most difficult the profession has ever experienced.

Throughout the course of the pandemic, however, skilled nursing facilities have taken — and continue to take — extraordinary measures to mitigate and prevent the spread of this virus, and our focus has remained the health and safety of our residents and staff. The efforts of our caregivers have saved thousands of lives.

Even as the primary focus must continue to be responding to the current crisis, all stakeholders have an interest in learning from this pandemic in order to properly prepare for the next one. Accurate reporting of all aspects of COVID-19 is an essential part of that learning and preparation process.

We are heavily regulated by both the federal and state governments, including reporting requirements related to COVID, and we make every possible effort to comply with all regulations. Ours is a profession of people caring for people, and we take seriously our mission of care for residents, families, and staff. This includes providing information on all aspects of COVID in our facilities. Information is critical in a pandemic, and this data should be used to help identify when and where resources are needed.

Minimal reporting was done in the chaotic first few weeks of the pandemic when little was known about the novel coronavirus, testing was not readily available, masks were homemade, and supplies of personal protective equipment were so scarce that isolation gowns were often garbage bags with holes cut for necks and arms. The only reporting during this period was reporting to local health departments designed solely to determine testing priorities.

The first systematic reporting requirements from either the state or federal government on COVID-related matters, including deaths, did not occur until mid to late April 2020 — a full month into the pandemic. In addition, reporting requirements changed on a regular basis, and

guidance on exactly how to report, to whom, exactly what, and when continued to change well into the summer of 2020 as regulators responded to additional knowledge of the virus.

The relationship between testing for COVID and reporting the number of COVID related deaths in skilled nursing facilities is important, because without proper, consistent, comprehensive, and timely testing, reporting the number of COVID deaths in skilled nursing facilities will be — at best — incomplete. Testing materials for skilled nursing facilities did not become widely available until the summer of 2020.

Skilled nursing facilities are currently required to report COVID-related deaths in their facilities once a week both to the state (EMResource system) and to the federal (NHSN system) governments, although the weeks are not consistent for the two systems. Although NHSN has a mechanism to correct errors or omissions, while EMResource does not, MDHHS completed three audits in an attempt to reconcile the numbers in the two systems. Data reported to EMResource is reported by the state to the federal NHSN in an attempt to relieve skilled nursing facilities of duplicating reporting, but many skilled nursing facilities continue to report to both because of difficulties in the transfer of data from the state to the federal system.

It is highly possible — indeed, likely — that inconsistencies will appear when examining and comparing different data bases or sources that might contain information on the location of COVID deaths. The following issues, among others, might be factors resulting in inconsistencies and need to be thoroughly reviewed before drawing any conclusions:

- Time frames utilized in reporting systems, the transfer of data between these systems, and subsequent data base analysis may result in different numbers of skilled nursing facility COVID deaths.
- Evolving reporting protocols and technical glitches with the primary reporting platform used by skilled nursing facilities to report COVID deaths in their facilities to the state may have resulted in data being initially deleted or inaccurately posted.
- The cause of death listed in the death certificate might not align with an earlier cause of death determination. For example, a skilled nursing facility resident might have tested positive for COVID at some point and had since recovered, but the actual cause of death, as determined by the attending physician, might be a known end state chronic illness such as Parkinson's Disease. A vital record review and comparison with COVID test records might note the earlier positive COVID test, and thus inaccurately list COVID as the cause of death. In other words, a COVID positive test occurring prior to death — sometimes long prior — does not necessarily mean that COVID was the actual cause of death. This individual's passing would not be reported by a facility.
- Multi-level care settings, such as assisted living, skilled nursing care, and independent living, occasionally share the same physical address, potentially creating inaccuracies in properly allocating or categorizing COVID death statistics.

- Communication challenges between health care settings likely caused unintended reporting omissions. For example, a skilled nursing facility resident with COVID who is transferred to and dies in a hospital or hospice setting might not get reported by the skilled nursing facility in their weekly report to the state as a "nursing home" COVID death. The final death certificate might, however, list the skilled nursing facility as the home address. Likewise, residents discharged without a known COVID diagnosis who later tests positive and dies may not be included in the reporting required by the facility.
- Incomplete reporting from providers could also have occurred. This was certainly the case during the early weeks of the pandemic with the lack of supplies, inadequate testing, the intensity of the rapid spread of the virus, and the desire to prioritize activities on the care of residents and limiting the spread of COVID-19. This likely also happened later and throughout the pandemic, as staff turnover mounted, including those responsible for reporting, and replacement staff needed time to become proficient on state and federal reporting requirements. The current staffing crisis in nursing facilities often necessitate dedicating available resources to providing direct care.
- Although the periodic audits completed by MDHHS to match EMResource numbers with NHSN numbers help ensure accuracy, no mechanism exists for later adjustments to the numbers reported weekly by skilled nursing facilities, even in cases in which these facilities receive additional information.

Accurate reporting must take these issues into account.

Interpretations and conclusions about COVID reporting related to skilled nursing facilities need to be made, however, in the context of the true nature of the COVID pandemic itself: the intensity of the spread of the virus; the initial lack of knowledge by health professionals on how to properly respond; few supplies and inadequate testing in the first months; staff challenges because of exposure to COVID; and changes in guidance from various levels of government throughout the course of the pandemic.