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COVID-19 INFECTION PREVENTION PROGRAM FOR I/DD SERVICE PROVIDERS: PROPOSAL FOR STATEWIDE IMPLEMENTATION (PREVENT THE SPREAD INITIATIVE)

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OVERVIEW

The COVID-19 public health crisis poses extensive risks and challenges for New York State's (NYS) most vulnerable populations. People with intellectual and/or developmental disabilities (I/DD) are recognized as exceptionally susceptible to COVID-19 given their health complexities, co-habilitative dwellings, and overall difficulty in navigating the healthcare system.

The I/DD service provider community acknowledges the risks posed to the health, safety, and well-being of people with I/DD residing both in the community and particularly within agency residences. Residential settings are at extreme risk with regards to the ability to implement proper infection prevention protocols given their home-like design. These settings were not created with isolation proximity guidelines in-mind, and consequently, group homes and other residential environments are at risk for high rates of infection transmission despite best efforts.

With the pandemic several weeks underway and with limited alternative funding options, service providers have little choice but to respond to the need for a wide-scale, programmatic approach through a "treat in place" model within residences to attempt to ensure the safety of people affected by COVID-19, while working collectively with healthcare partners to ease their current capacity strains. While service providers have attempted to accommodate both COVID-19 positive/presumed positive and COVID-19 negative people within residences, it has not prevented the spread of the virus for a number of reasons, including challenges with social distancing, maintaining proper hygiene, close-proximity quarters, shared bedrooms, limited bathroom facilities, etc.

A more methodical approach with two residential models of care outside the current home, to separate people who are infected or presumed infected, is critically needed in order to safely care for people with I/DD. The first residential care model is one that is basic and needed solely for separation and recovery. The second residential care model is a more intensive setting with clinical supports to primarily support people discharged from the hospital until fully recovered or no longer requiring an enhanced level of support. This program will address the infrastructure and funding support needed to successfully employ such residential models

which will ultimately aid in preventing COVID-19 transmission amongst people with I/DD and agency staff.

Lastly, the I/DD service provider community recognizes the ongoing threat COVID-19 may pose beyond the current "wave" of infection and views this program as both a short- and long-term solution to address current and future needs of people with I/DD. We believe the proposed model would allow providers the flexibility to move quickly to ensure the safety of those living with them and to provide a resource for people living in their own homes as well as those in agencies not able to provide the care models this initiative would establish.

PROGRAM OBJECTIVES

The I/DD service provider community across NYS collectively recognizes the immediate need for the following actions:

- Implement a provider-led, statewide program to appropriately care for COVID-positive, and COVID-presumed-positive people with I/DD and to prevent the spread of COVID-19 infection amongst the I/DD community and staff
- Employ two models: a basic model within a temporary residence that supports separation through isolation with a focus on recovery. A second model, a comprehensive clinically supported model within temporary residences, to more efficiently accommodate hospital discharges and/or avoid hospital/Emergency Room (ER) encounters or nursing home transfers by providing clinical equipment and staffing
- Utilize existing I/DD service provider infrastructure (staffing, space, etc.) to support COVID-19-positive people from both community and residential settings with appropriate infection prevention supports and safeguards
- With support from NYS Care Coordination Organizations (CCOs), develop a model of triage, assessment and isolation that sets a standard for the I/DD population and can be replicated across NYS and the country to prevent COVID-19 infection and reduce mortality rates for people with I/DD
- Maintain financial viability and sustainability of NYS' I/DD service provider community to ensure the State's most vulnerable continue to receive the services and supports they need, both during and after the COVID-19 pandemic.

PROPOSAL

New York Disability Advocates (NYDA), with the support of the CCOs, propose a comprehensive, state-wide, provider-led program to prevent and manage the spread of COVID-19 infection within the I/DD population. To accomplish this, providers, with support from State agencies and stakeholders, must modify current space capacities, staffing patterns and

clinical provisions to accommodate people in a manner which upholds safety and infection prevention standards. Additionally, providers must modify existing housing and staffing patterns to ensure COVID-19-positive and COVID-19-negative people are separated sufficiently to prevent the spread of infection and possible subsequent hospitalizations. Data from the seven CCOs suggests that, of people with I/DD tested positive or presumed positive, over 80% live in group homes. Of that cohort, more than half experience a hospitalization due to their COVID-19 positive status. Thus, it is imperative that overall hospitalizations are prevented by implementing a stringent isolation protocol for those who are COVID-19-positive.

This proposal addresses COVID-19 safety protocols for the following populations:

- People with I/DD residing in their current residential settings who require isolation protections
- People with I/DD residing in the community who need temporary residential accommodations and may require isolation protections
- People with I/DD residing in the residential setting who require higher level of clinical care in another I/DD residential setting
- People with I/DD prematurely discharged from hospitals or sent home from ERs and refused admission when COVID-19 positive or presumed positive.

With support from CCOs, who will play a centralization and coordination role within this program, providers will assess their ability to establish temporary residential models based upon staffing, space, and clinical capacities. Based upon that assessment, providers will determine the number and type of models they can respectively support. Each provider will share this information with identified CCOs, who will work with providers to maintain updated information related to each temporary residential model location, capacity and vacancies for each provider.

Upon the collection and centralization of this data, CCOs will act as 24/7 statewide triage units to coordinate appropriate care for people with I/DD, dependent upon COVID-19 status and isolation needs. Examples of common scenarios include:

- People with I/DD recently discharged from the hospital with COVID-19-related complications who are still infectious but could be cared for outside the hospital setting with appropriate clinical supports; these people require isolation precautions and must be cared for using appropriate PPE
- People with I/DD who are COVID-19 positive, and, with the appropriate clinical supports, can remain in a residential setting while avoiding a hospital/ER encounter; these people require isolation precautions and must be cared for using appropriate PPE
- People with I/DD who are presumed-COVID-19 positive (may be symptomatic or asymptomatic); these people require isolation precautions and must be cared for using appropriate PPE

- People with I/DD who are COVID-19 negative and need to be separated from COVID-19 positive people in order to prevent the spread of infection.

People with I/DD requiring the above support may present from the community or within their own agencies. In limited cases, providers anticipate there may be a need for agency-to-agency transfers if a higher level of clinical support is needed for people residing in a residence that does not currently have sufficient clinical capacities. In these scenarios, and for people residing in the community who require temporary residential placement, agencies will work with DDROs on eligibility processes needed to execute placement.

When people with I/DD in the above scenarios are identified, triggers to the centralized CCO triage team will be enacted, and in collaboration with healthcare providers, disability agencies, and CCO Care Managers, appropriate placement will be identified based on level of clinical support required and isolation precautions needed. When clinical decisions within an agency support movement to a temporary residential model managed by the same agency, the agency will notify the Care Manager and family members/caregiver regarding the decision to move the person to the temporary residential location. The CCO triage team will work with Care Managers and providers to ensure safe transfers are initiated, documentation is obtained, and families/caregivers are kept informed. The receiving agencies will employ the proper clinical supports and isolation precautions as recommended by the healthcare provider(s) (if applicable) and status of the person will be monitored by the agency and Care Manager.

Longer-term, this model sets forth the infrastructure and staffing paradigms needed to establish a comprehensive, public-health-minded plan for caring for people with I/DD during an infectious disease outbreak. Upon initial implementation of the above plan, agencies will continue to collaborate on critical areas such as testing, contact tracing, PPE stockpiling, and workforce capacities to ensure the service provider community is fully prepared for future outbreaks, as predicated by public health experts.

Throughout the course of care delivery, agencies will follow all isolation precautions and infection prevention measures as recommended by both the Centers for Disease Control (CDC) and the NYS Department of Health (DOH). For people receiving higher levels of clinical supports and/or isolation measures, agencies will defer to the person's treating clinician(s) and CDC/DOH guidance as to when clinical and isolation measures can be relaxed.

TIMELINE

NYDA recommends this program be implemented as soon as possible so people with I/DD are ensured the highest levels of care during the COVID-19 pandemic. The planning phases of this program have been initiated; NYDA now looks to State agencies for approval of the funding mechanisms necessary to fully implement this model. Further, should there be a reduction in need, these models would go "offline" and be readily reactivated at such time future waves of

COVID-19 demand swift response by providers to enact an isolation and quarantine protocol with these units to stem the spread and ensure the safety and health of their residents.

FUNDING MODEL

In order to be eligible, I/DD service providers will be required to provide a signed attestation to the NYS Office for People With Developmental Disabilities (OPWDD) that they are prepared to open the basic temporary residential model and/or the clinically intensive temporary residential model. These models will require enhanced funding to support the higher acuity and clinical capacities needed to safely care for people with I/DD and prevent further spread of COVID-19 amongst this community. This proposal requires the following funding mechanisms for full implementation:

- Enhancement of residential provider IRA/ICF rates by 2% percent for the basic model and 2.5% percent for both the basic and the clinical based model that would be activated during an outbreak and initiated by individuals with I/DD testing positive or presumed positive in need of isolation. The % increase is low because the enhanced rate is billed across the residential providers entire IRA and/or ICF capacity.
- Approval of Respite funding, at the site-based fee (approximately $600 for 24/7), for people with I/DD coming from the community, or from another service provider, as approved by the DDRO.

The above funding mechanisms are proposed considering well-known financial strains currently placed on the I/DD service provider community, even prior to the COVID-19 public health crisis. The savings to the system for the acute care discharge to the clinically intensive model as well as the avoided acute care admissions will assist in offsetting additional costs to the system. The additional challenges COVID-19 presents for people with I/DD and service providers must be met with financial and economic backing that ensures people with I/DD receive safe, timely, clinically enhanced care during these unprecedented times. *While the I/DD service provider community stands ready to answer this call, it is imperative that State and Federal financial provisions are in place to sustain service provider viability both during and after the pandemic.*

CONCLUSION

NYDA appreciates the continued collaboration with State and Local entities during the COVID-19 crisis and looks forward to further discussion on next steps in implementing the above program.