Public Health
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Public Health – Seattle & King County Adult Family Home COVID Response Summary

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COVID Response for Adult Family Homes in King County
Lessons Learned and Recommendations

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Overview

This paper describes Public Health – Seattle & King County's (PHSKC) response to COVID outbreaks in Adult Family Homes (AFHs) and lessons learned. While the most extensive outbreaks in King County have occurred in nursing home settings, AFHs have also been impacted. As of July 31, 2020, 4.9 percent of the 1,176 AFHs in King County have experienced an outbreak, with a total of 171 positive cases and 43 deaths.[1]

PHSKC responds to AFH outbreaks with infection control and prevention support, testing support, and assistance in securing appropriate personal protective equipment (PPE). Due to their size and other unique characteristics, an outbreak can quickly destabilize an AFH and, in some cases, result in the transfer of residents to hospitals or skilled nursing facilities.

PHSKC implemented a pilot project designed to proactively uncover outbreaks through point prevalence surveys (PPS), defined as testing of all residents and staff. The project only included facilities that at the time of testing did not have any associated confirmed cases. The scheduling and preparing for testing events in this sector proved to be very labor intensive due to many factors, including the small size of the facilities and their lack of administrative support and communication technology. The pilot project completed testing in 59 AFHs, revealing one COVID-positive case.

Based on the lessons learned and outcomes of the PPS pilot project, PHSKC does not currently recommend PPS of all AFHs in King County. The identification of one case among those tested and the logistical challenges and structural barriers to PPS in AFHs is not commensurate with the potential gains. A more targeted PPS approach, focusing on staff that work in multiple AFHs or other long-term care facilities (LTCF), may provide some benefit. PHSKC does recommend policy and system changes to enable sustained capacity for testing within this sector and crosscutting support to this sector to reduce COVID risks.

Background on Adult Family Homes

In Washington State, AFHs serve a population of older adults and people with disabilities who need support with daily living activities. Many are eligible for Medicaid-funded nursing home level of care, but choose to live instead in these smaller, community-based homes. The State Department of Social & Health Services (DSHS) licenses AFHs to care for up to six residents, with care provided by certified home care workers and nursing assistants. A small number of AFHs are owned by a healthcare provider, but generally AFHs do not have in-house medical staff and allowable nursing tasks are performed under the supervision of a nurse delegator. Some AFHs are certified to provide specialized care for people with mental health issues, developmental disabilities, or dementia.

As shown in Table 1, DSHS licenses 1,176 AFHs in King County. Of those, over 40% are located in south King County, with clusters of homes in cities and neighborhoods with low socio-economic indicators and high percentages of people of color. Many are owned and operated by immigrants.

[1] Data in report represents information available as of July 31, 2020

Table 1: Details on King County AFH Capacity and Medicaid Status

Capacity of Adult Family Homes			Medicaid-Contracted Adult Family Home Subset		
Number of Facilities	License Bed Capacity	Average Capacity	Contracted Facilities	People Served Based on Claims	Medicaid Clients % of Licensed Beds
1,176	6,686	5.69 beds	1,007	2,602	46%

While most are sole proprietorships, 200 AFHs (17 percent) in King County are part of a group of homes owned and managed by a single owner (Table 2). Providers report that some staff from these groups of homes work at multiple sites. Over 40% of the multiple homes owned by one provider are located in south King County.

Table 1. King County AFHs by number of homes of single owner

Number of AFH Providers/Owners	Number of AFH Businesses Owned
976	1
64	2
14	3
5	4
2	5

COVID Outbreaks in Adult Family Homes

Residents of AFHs are at high risk of severe illness and death from COVID, due to age and underlying health conditions. Once COVID is introduced, spread within the facility can happen quickly because residents live in a congregate setting that puts them in close proximity to others. Residents frequently share bedrooms and bathrooms, and they have close bodily contact with staff who provide personal care assistance with bathing, dressing, and eating. Table 3 describes the reported COVID AFH-affiliated cases.

Table 3. COVID Impact on AFHs

Attribute	Value
AFH with at least one case	58
Total cases overall	171
Total deaths	43

The number of AFHs with at least one case includes sites identified from reactive testing events, a pilot PPS project (using a proactive approach), and when independent testing identified cases (e.g. matching lab results, syndromic surveillance, AFH owner reports). Individuals are determined to be a resident or staff of a facility through a PHSKC planned testing event (PPS and reactive) or when tested at the behest of their medical provider.[2] The actual number of cases and deaths in this sector may be higher, as not all cases will be associated with an AFH if a resident's reported address upon seeking medical care does not match that of the AFH where they have been living, or if individuals are simply not tested.

The primary interventions for COVID outbreaks in LTCFs are applied through a multipronged response. All LTCFs, including AFHs, are required to notify PHSKC when a resident or staff member tests positive for COVID or when they have a cluster of individuals with COVID-like illness. A PHSKC disease investigator responds to these calls to assess the situation, schedule an infection control and prevention visit (in-person or remote), and arrange testing of all residents and/or staff (reactive testing event). From this initial contact, PHSKC requests that these facilities

[2] There are two types of testing methods utilized: proactive, where the testing date occurred before an investigation was initiated, and reactive, where the date of testing occurred after an investigation was initiated. The pilot PPS project utilized the former approach.

continue to report the outbreak status and stay in contact with disease investigators for ongoing infection control and prevention guidance until no new cases have been identified within a 28-day period.

As seen in Table 4, there were 32 reactive testing events performed in 27 AFHs, producing an overall positivity rate of 26.7% when including all individuals.

Table 4: Summary of reactive testing in AFH

Number of Reactive Testing Events	Number of Facilities	Total Cases Found via Reactive Testing	Number COVID-positive Resident identified/Number Tested (Positivity Rate)	Number COVID-positive Staff identified/Number Tested (Positivity Rate)
32	27	63	24/110 (30.9%)	29/126 (23.0%)

Unique Challenges for Impacted Adult Family Homes

AFHs have limited capacity to manage outbreaks. There are typically one to three staff dedicated to each AFH, and in the face of an outbreak, maintaining stable staffing is a challenge. Most have very limited access to back up staffing for employees who test positive for COVID and take time off to isolate, and/or need time off for other reasons. Staff who are uninsured or who do not have sick leave may be reluctant to agree to testing. Additionally, it is often challenging to implement cohorting, the separation of sick residents from those who are well, if residents share bedrooms and/or bathrooms. Finally, AFHs struggle to access the personal protective equipment (PPE) necessary to prevent transmission. While larger facilities have the capacity to source PPE from regular distributors or corporate partners, most AFHs do not have access to these supply channels.

Because of these characteristics, AFHs are uniquely vulnerable to COVID outbreaks resulting in instability of resident care and the necessity to move residents to other settings. If a facility is highly impacted and no longer able to care for COVID-positive individuals due to insufficient staffing and/ or high transmission risk, PHSKC alerts DSHS, which is responsible for ensuring quality of care for residents and for transferring residents to other LTCFs or hospitals, if necessary. Table 5 provides case examples of COVID outbreak issues that occurred in AFHs.

Table 5. Case examples of issues experienced by AFHs experiencing a COVID outbreak

Facility	Total Positive Cases	Number Licensed Beds	Key Outbreak Issues and Outcomes
AFH #1	8 (4 staff, 4 residents)	6	Initially, one positive staff was identified and a symptomatic resident was transferred to an acute care hospital. With additional positive residents and staff, one remaining caregiver worked for 2 weeks with no relief except some assistance from a newly licensed nursing assistant. The facility eventually transferred the remaining patients to other nursing facilities, as the owner could not provide adequate care for the residents. One COVID-positive resident later died.
AFH #2	8 (2 staff, 6 residents)	6	An employee who worked at AFH #2 and at 3 other AFHs initially tested positive. Soon after, one symptomatic resident needed transfer to an acute care hospital. Staff and residents at all 4 AFHs were monitored for COVID symptoms and tested as needed. Reactive testing in this AFH (as well as the other 3) identified additional staff and residents as COVID-positive. The same owner of all sites was overwhelmed with the difficulty of maintaining enough staff across

			the multiple homes, providing adequate PPE supply for resident care, and preventing further spread of the virus.
AFH #3	6 (1 staff, 5 residents)	5	Two symptomatic residents were transferred to an acute care hospital and tested positive; subsequently, both residents died. An additional 3 residents tested positive, as did the owner. The owner requested assistance in filling an urgent PPE need. The COVID-positive owner was the only caregiver available for some time. Other staff were not working because of own symptoms and/or pending tests. The case was elevated to DSHS who decided to move the 3 residents to another facility for their care and to give the owner time to get well. The owner temporarily was not admitting new residents.
AFH #4	7 (3 staff, 4 residents)	6	The facility reported that 4 residents and 3 staff were asymptomatic COVID-positive. The owner received guidance on infection control steps to protect healthy residents, PPE ordering, retesting, and how to acquire basic supplies while residents and staff were in isolation and quarantine.

Pilot AFH Point Prevalence Testing

In response to the outbreaks in AFHs, PHSKC conducted a pilot study to test the effectiveness of PPS, defined as testing of all residents and staff at one point in time, a strategy recommended by the Center for Disease Control and Prevention (CDC) (CDC Coronavirus Nursing Homes Testing) for nursing home settings. Facility-wide testing can identify asymptomatic and pre-symptomatic persons and inform infection prevention measures. This approach involved working with partners to offer testing, coordinating supplies, reporting results, and recommending infection prevention measures based on results. The pilot was performed in a proactive manner; only facilities not currently associated with a confirmed or suspect case were recruited to participate.

Testing in AFHs is far more difficult to arrange than in skilled nursing facilities because there is no medical director to order the test, many of the workers are uninsured, and AFHs often do not have staff that can perform the COVID testing. To overcome these barriers, PHSKC used its own clinician to order tests, assumed the cost of testing for uninsured staff, and provided support for specimen collection through its own testing team or secured from testing partners.

The goals of the pilot were to: 1) assess the current burden of COVID cases in AFHs; 2) identify barriers to ongoing testing in these settings; and 3) develop partnerships to inform a sustainable testing model. The pilot tested in 59 AFHs, including 15 in Seattle with testing organized by the Seattle Fire Department, and 44 in south King County with coordination between PHSKC, the AFH Council, and the State Long Term Care Ombudsman Program.

As seen in Table 6, there were 60 PPS testing events performed in AFHs; one positive staff member and no positive residents were identified producing an overall positivity rate of 0.2%.

Table 6. Summary of proactive pilot testing in AFH

Number of Proactive Testing Events	Number of Facilities	Total Cases Found via Proactive Testing	Number COVID-positive Residents Identified/Number Tested (Positivity Rate)	Number COVID-positive Staff Identified/Number Tested (Positivity Rate)
60	59	1	0/286 (0.0%)	1/215 (0.5%)

During outreach for the pilot PPS, several AFHs declined participation. Some reasons AFHs did not want to participate included: concern about testing teams introducing the virus to the facility; had initiated infection prevention measures early on (including visitor limitations) and saw no need to test asymptomatic residents/staff; resident's family not wanting the resident tested; and, concern for a potential financial obligation (even when it was explained there were no costs associated with pilot participation).

Lessons Learned

Based on feedback and experiences of PHSKC teams, project partners, and AFH providers involved in reactive and point prevalence testing, the following are some lessons learned:

- **AFHs have smaller outbreaks than other types of LTCF due to their smaller size, but if the virus is introduced into the home, they have difficulty containing the virus and can quickly become unstable.**
- **The large number of small facilities dispersed across a broad geography create logistical barriers to completing sector-wide testing.** It is possible for a testing team to bundle testing events within the same neighborhood and complete testing at 4-5 AFHs within one day. When this is not possible, it is difficult for a team to maintain economies of scale and be fully utilized as significant time is spent traveling to and between the sites.
- **Scheduling is a time-consuming endeavor.** Scheduling AFH sites for a testing event can take several attempts in order to connect with the owner to discuss the logistics. Some sites need to reschedule, often on the day of testing, if the owner has not been able to prepare or other issues in the home come up unexpectedly and make it impossible to have a testing event. AFHs do not have clinical or administrative staff available with dedicated time to complete paperwork and set up testing, so preparing for testing can be more burdensome for this sector.
- **Access to a provider to order tests for all resident and workers improves accessibility.** For many King County AFH testing events, PHSKC was the ordering provider allowing a quick response for proactive and reactive testing and eliminated a primary barrier. For the pilot PPS, the small number of sites tested made it feasible, but countywide point prevalence testing would require extensive partners and staffing to ensure full testing compliance, including the responsibility of the ordering provider to return results to the AFH owner.
- **Securing verbal consent for testing must happen in advance of a testing event.** AFH owners have various health care proxies (e.g. power of attorney, guardians) that they must contact to get consent for tests if the resident is not able to consent on their own. During the pilot PPS, some AFHs declined to participate as residents' families did not want their family members to test if asymptomatic.
- **Concerns about cost are a deterrent to testing.** Some AFHs owners expressed hesitancy or declined to participate in the pilot PPS due to concern over possible financial obligation of the resident, staff member, or themselves for costs not covered by insurance or uninsured status. Partners have indicated that it is likely that many AFH healthcare workers are uninsured, reflecting a need for a system change to assist workers with testing coverage.
- **Multi-lingual, multi-cultural response capacity is key.** The AFH sector employs a large workforce and provides care often within a multi-lingual and multi-cultural home. This highlights a best practice opportunity to work in collaboration with owners and healthcare workers to co-create infection control and prevention planning guidance and response plans that are accessible, culturally sensitive, and relevant.

Recommendations

Based on King County COVID surveillance data and experience from reactive testing and the pilot PPS, PHSKC does not recommend full point prevalence testing of all King County AFHs at this time. While this strategy may be possible in smaller jurisdictions, it is currently not a feasible option for the more than 1,000 facilities in King County's large metro area. State-level policy and system changes are urgently needed to ensure a sustained capacity for ongoing monitoring and testing for COVID in this sector. In the interim, PHSKC recommends a multi-faceted approach to preventing outbreaks in AFHs including targeted testing of a subset of facilities identified to be most vulnerable, rapid reactive testing when an AFH reports a positive case, and crosscutting support that leverages community partnerships:

Testing:

- **A rapid response with reactive testing and infection control and prevention guidance to support impacted AFHs.** Ongoing outreach to AFHs is necessary to ensure that they understand mandatory reporting requirements for notifiable conditions, including COVID. Timely reporting will enable a quick and timely response from PHSKC, including reactive testing and infection control and prevention guidance. Reactive testing should include all residents and staff, assuming all have some level of exposure risk, not only those who are symptomatic.
- **Full PPS of all King County AFHs is not recommended at this time.** As illustrated in this report, there are numerous barriers to completing a PPS in this sector. In the current state, the investment of time and resources necessary to complete a PPS is not commensurate with the potential gain of uncovering positive residents or staff who would not otherwise be detected. In addition, because AFHs do not have staff on site who can continue to conduct testing on their own in the future, the value of PPS testing as a training exercise is not accomplished as it is in larger facilities such as nursing homes. Finally, testing in AFHs brings a small risk of transmission of the virus from the testing team to the residents and staff because of their extensive travel between multiple facilities and the AFHs may not be able to provide safe testing areas (e.g. outdoor area or dedicated large room).
- **Targeted PPS approaches may be warranted to address facilities with increased risk factors for transmission**. Focused testing of all residents and staff may be beneficial for example, when a facility has: a) healthcare workers who work in multiple AFHs or in other LTCF, and/or b) residents leaving the facility on a regular basis for work, dialysis, chemotherapy, or other ongoing medical treatment.
- **Support easy access to testing and healthcare.** AFH staff pose a transmission risk from the broader community into the AFH. To prevent this, staff should be encouraged to test promptly if they have any concern regarding exposure. If testing at the AFH is not available, staff should be provided with testing location information (King County COVID Testing Locations), including open access testing sites. In the absence of employer-based insurance, focused outreach to enroll eligible individuals into public health insurance plans, including Medicaid and Qualified Health Plans, and connecting undocumented individuals to services is recommended.

State Policy Changes Necessary to Sustain Ongoing Retesting:

- **Medical oversight at the facility level.** All AFHs need to be required to have an emergency pandemic plan in place and an identified licensed health care provider to coordinate communicable disease monitoring and response efforts in their facility. Home health staff who may already have relationships with and regularly visit clients at these facilities should be leveraged. PHSKC recommends that the Health Care Authority investigate the feasibility of expanding home health's role under Medicare and Medicaid for this purpose.

- **Coverage for COVID-testing and COVID-related care for all staff working in LTCFs.** Clear policy to enable reimbursement for COVID-testing and related care for all staff working in LTCFs, including those who are undocumented, is needed. Funding allocated to AFHs for health benefits should be increased and facilities should be held accountable for ensuring health coverage of all staff (through an employer-based plan or Qualified Health Plan) and for coverage for co-pays or deductibles associated with COVID-testing or care.

Crosscutting, Sector-wide Support:

- **Technology upgrades.** Not all AFHs have up to date computer systems and internet access. Ensuring that facilities have enhanced technology capabilities will allow for improved communication, use of telehealth consults, access to laboratory results, expedited testing and reporting, and increased ability to interface with local and state health agencies on necessary documents and data.
- **Learning opportunities.** Providing consistent and clear messaging that highlights infection control planning, testing, and assessment will be critical for continued learning. Ongoing training and response planning is already being done by many partners and building on these assets will be beneficial. The multi-lingual/multi-cultural environments of many AFHs requires time and focus on co-creating guidance with AFH providers to ensure that resources are accessible and relevant. Technology, in conjunction with in-person assistance, can help provide more learning opportunities.
- **Community partnerships.** Partnerships between local and state health agencies, sector-focused organizations and agencies, and AFH owners can help to ensure there is timely and ongoing support for staff and residents. Swift and coordinated responses to outbreaks in facilities will reduce pressure on the healthcare system overall, especially if residents are able to stay in their home. Due to the size and staff capacity of AFHs and vulnerability of residents, it is critical that AFHs have access to resources to maintain resident care. In outbreak situations, partners working together may assist with supplying urgent PPE, coordinating backup staffing, and transferring COVID-positive residents to other facilities for additional care as a way to keep other residents healthy if necessary.

Conclusion

COVID is likely to be an ongoing, long-term challenge in AFHs. As counties reopen, spikes in cases in the broader community are expected. In all LTCFs, the rise in community spread of COVID, in combination with the lifting of visitor restrictions will likely lead to ongoing outbreaks. As the experience in King County illustrates, mitigating this risk in AFHs will require a multi-faceted approach. In addition to the ongoing response role of the public health sector and state licensing and regulatory agencies, it is essential to invest the adequate resources in order to establish the sustainable infrastructure necessary to support ongoing testing capacity and communicable disease prevention for AFHs and all LTCFs.