Smaller nursing homes, as measured by average residents’ daily census, were less likely to report COVID-19 data (odds ratio (OR) =0.96; P < .001). Nonchain nursing homes were less likely to report data (OR = 0.74; P = .001). When comparing nursing homes with four-star quality ratings, nursing homes with three-star ratings were less likely to follow instructions and report COVID-19 data to CMS (OR = 0.75; P = .044). Measured by years of operation, newer nursing homes were less likely to report COVID-19 cases (OR = 0.99; P = .014). Nursing homes with a higher percentage of White residents and residents aged 65 years and older were less likely to be late reporters (OR = 0.996 (P = .05); and OR = 0.991 (P = .001), respectively).

**DISCUSSION**

Participation in data reporting requires particular information technology infrastructure and additional human and financial resources, which may create barriers for smaller nursing homes. A recent study found that smaller nursing homes had a lower probability of having any COVID-19 cases, but after adjusting the size, they had a much higher outbreak size compared with nursing homes with more than 50 beds. It is possible that smaller nursing homes had more COVID-19 cases adjusted by bed capacity. Therefore, they did not have additional resources to report to CMS. A similar trend was observed between chain-affiliated and freestanding nursing homes. Nonchain nursing homes may lack resources to conduct reporting, and they were more likely to have COVID-19 cases. The finding of this study may signal a need to help small and nonchain nursing homes in receiving incentives or resources from CMS to overcome barriers in COVID-19 reporting. Nursing homes that operated longer in the market were more familiar with the requirement by the government in quality reporting, and they were more prepared with resources to comply with COVID-19 reporting.

A study found that older adults (aged >65 years) faced a higher risk in getting COVID-19 and developing into critical conditions. With more severe cases and higher death rates from older residents, especially those who are older than 65 years, nursing homes may pay more attention to COVID-19 reporting. We also spotted the racial disparity in reporting COVID-19 cases. Nursing homes with a higher percentage of minority populations were less likely to participate in reporting. Previous studies found that minority residents in nursing homes were more subject to coronavirus, which indicated a disproportionate impact of COVID-19 among different racial and ethnic groups. Our study is consistent with previous findings, and CMS may need to focus on nursing homes with more minority residents and explore the underlying reasons for the disparity in COVID-19 reporting and residents’ cases and deaths.

In conclusion, CMS successfully collected COVID-19 data from nursing homes with a wide geographical variation in participation. Additional support may be needed to help small and nonchain nursing homes to make sure they have sufficient resources to comply.

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**Ready or Not: Pivoting to Video Visits with Homebound Older Adults During the COVID-19 Pandemic**

To the Editor: In 2018, our home-based primary care (HBPC) program embarked on a direct-to-patient telehealth pilot. At that time, results were accurately characterized by the title: “Not yet ready for prime time,” as reported in this
journal, with only 7.9% of eligible patients successfully completing at least one telehealth visit (39/493). Barriers to telehealth visits included technical, operational, and access issues. These issues led to rethinking our strategy, and our subsequent pilot used trained emergency medical technicians to bring the video platform to the patient’s home for a telehealth visit with their primary care physician. Here we describe our third telehealth iteration, this time during the COVID-19 pandemic, in a program designed to serve chronically ill homebound older adults.

As part of an integrated health system, our program provides comprehensive primary care to approximately 2000 chronically ill homebound patients residing in downstate New York. We use a multidisciplinary team composed of physicians, nurse practitioners, nurses, social workers, and medical coordinators. A meaningful 24/7 clinical response is achieved through a nurse clinical call center and telehealth-enabled community paramedicine program that can evaluate and treat enrollees in the home under the direction of an HBPC physician, transporting to the...
hospital only when medically necessary and aligned with goals of care.²

During the New York COVID-19 pandemic surge, our program faced a new reality in which face-to-face contact conferred a serious risk of disease transmission for both staff and program enrollees. Ready or not, we pivoted to an expansive phase of direct-to-patient telehealth. We rapidly shifted most care delivery from in-home, face-to-face visits to remote telehealth and telephonic care. We leveraged existing staff to rapidly reach large numbers of patients for telehealth consent in advance of planned appointments, walking them through downloading and testing the Health Insurance Portability and Accountability Act (HIPAA)-compliant telehealth application so the scheduled clinician was prepared to conduct the visit.

Participation in telehealth visits by enrollees during the early spring COVID-19 surge was remarkably greater than in our 2018 pilot. Between March and May 2020, our program continued to treat a high number of chronically ill older adults (1712 unique individuals; average age = 82.5 years; 66.6% with five to six activity of daily living dependencies) and observed an increase to 48.6% of eligible enrollees successfully completing at least one telehealth visit (643/1,323) compared with the 7.9% in 2018.

Although a remarkably greater proportion completed a telehealth visit compared with 2018, an even greater proportion of 74.8% of eligible patients consented to using telehealth and were instructed for downloading the application (989/1,323). Of 26.2% of patients who consented to using telehealth but who did not complete a telehealth visit, 32.9% completed at least one face-to-face visit (114/346). Additionally, 194 had only telephonic visits, and 38 had no scheduled visits during this study period (Figure 1). Of note during the pandemic, 85 (9%) of scheduled telehealth attempts were unsuccessful and had to be completed by telephone.

On reflection, the need to obtain telehealth consent and download a HIPAA-compliant application remained a barrier to completing telehealth visits. However, an important component of rapid deployment was leveraging nonclinical staff to consent and conduct previsit preparation. Additionally, when the first choice platform was unsuccessful, waivers of telehealth HIPAA regulations allowed providers to use telehealth with a larger number of patients.⁴

The unique set of circumstances created by the COVID-19 pandemic, including the need to physically isolate to prevent disease transmission as well as changes in telehealth reimbursement, motivated our providers, program enrollees, and their caregivers to embrace this modality at rates dwarfing our prior direct-to-patient telehealth attempts. We found telehealth to be a viable solution for providing continuity of care to highly vulnerable patients at risk for poor outcomes due to the pandemic. Enrollees and caregivers who were otherwise unable or unwilling to consider telehealth an option now sought it out, purchasing devices and looking to formal and familial caregivers to help facilitate visits when they were unable to do so on their own.

We caution that, although telehealth has expanded ways for providers and patients to connect, there remain significant subset of patients who are unable to access telehealth. In these situations, we used either telephonic or face-to-face visits. The “digital divide” remains prominent among older adults and has the potential to increase isolation and decrease access to care.⁵ Additionally, we would not suggest that telehealth visits fully replace face-to-face visits at any point. Aspects of the physical examination that can only be performed in person remain of paramount importance in accurate and appropriate care provision in certain cases, and personal connection, a foundation in a trusting relationship, may be more difficult to achieve through a video visit. Further study on outcomes of older adults receiving care through telehealth is needed, including chronic and acute disease management, impacts on acute and post-acute care utilization, days home, and measures of isolation and depression.

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