STATE OF MICHIGAN

GRETCHEN WHITMER
GOVERNOR

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

ELIZABETH HERTEL
DIRECTOR

MEMORANDUM

DATE: January 9, 2021

TO: Doug Ringler
Auditor General

FROM: Elizabeth Hertel
Director, Michigan Department of Health and Human Services

SUBJECT: Final Review, Long-term Care COVID-19 Mortality Reporting Response

Thank you for the time and energy you and your staff have put into reviewing the information that MDHHS collects and shares regarding the number of individuals who died of COVID-19 in our nursing homes, adult foster care facilities, and homes for the aged. As you and your team recognize, the data under review has been self-reported by facilities. I appreciate your recognition of the fact that MDHHS accurately compiled and published the long-term care COVID-19 death data supplied by Michigan's long-term care facilities, as well as your recognition of MDHHS's work ensuring the reasonableness and integrity of the data reported.

I want to recognize your team's willingness to learn about and try to understand the complexities of these industries and our data collection and reporting systems in just a matter of months. I also appreciate the opportunity to review and provide feedback on your initial analysis. Nevertheless, I continue to have serious concerns about both the methodology employed to compare long-term care facilities' self-reported data to death certificate data from Michigan's Electronic Death Registry System and COVID-19 case and death data from the Michigan Disease Surveillance System, as well as the conclusions you've drawn from this review. I fear that your letter will be misinterpreted to question the work and integrity of long-term care facilities, local health departments, coroners, and other frontline workers who we rely on to report data.

Specifically, we remain concerned about each of the following issues, which I called to your attention during our earlier discussions:

- Your analysis relies on a reconciliation of data with different definitions.
- Your letter does not assess the accuracy of self-reported long-term care data. Such an analysis would require facility-by-facility investigation.
- Your analysis relies heavily on the Michigan Disease Surveillance System data despite my noted concerns that this system is designed for surveillance, not death investigation;

therefore, it is not an appropriate source for determining if a COVID-19 case resulting in death should be counted in long-term care mortality reporting.
- The letter combines COVID-19 deaths in facilities that were required to report and those that were not required to report, creating the impression of a larger undercount by long-term care facilities than is warranted.

Because of these issues, we do not believe you have done a "proper accounting of all long-term care facility deaths" as your letter suggests.

The Office of the Auditor General's analysis relies on reconciliation of data with different definitions

Most significantly, your analysis does not apply the CDC definition of a COVID-19 death reportable by a long-term care facility. A reportable long-term care COVID-19 death is defined by the National Healthcare Safety Network as a resident who died from COVID-19 related complications and includes resident deaths in the facility, and in other locations in which the resident with COVID-19 was transferred to receive treatment. Residents not expected to return to the long-term care facility are excluded from the count. MDHHS has always required long-term care COVID-19 deaths be reported consistent with this standard set by the federal government.

While your letter cites the World Health Organization's definition of a COVID-19 death, ***it is unclear how you are defining the relevant subset of long-term care COVID-19 deaths***. From your methodological choices, we know that your count includes the following categories that do not meet the definition of a reportable COVID-19 long-term care death:

- Individuals who had been discharged from a long-term care facility prior to their death. This category includes former residents who recovered from COVID-19 and then subsequently returned home to be with their families or were discharged to hospice.
- Individuals who were hospitalized for a non-COVID-19 reason, such as a fall, and then subsequently acquired COVID-19 outside of the long-term care facility.
- Individuals who did not reside at a long-term care facility that was required to report, but instead resided at a non-reporting facility on a shared campus such as a Continuing Care Retirement Community.

As discussed above, long-term care facilities were only required to report COVID-19 deaths within the definition provided by CDC. Stating that long-term care facilities that did not report deaths in the above categories "underreported" deaths is simply not accurate.

The Office of the Auditor General did not assess the accuracy of the self-reported long-term care data

Your report notes significant limitations associated with the data analysis you were able to conduct, including that you were unable to exclude:

- Individuals who were not residing in a long-term care facility at the time of death;
- Those who were not diagnosed with COVID-19 when transferred to the hospital for care for unrelated reasons; and
- COVID-19 deaths that occurred at independent or assisted living facilities that share an address with a licensed long-term care facility.

By including these individuals in your count, ***you are using a different definition of a reportable long-term care COVID-19 death than required by the CDC***. Any accurate count of long-term care COVID-19 deaths should use the federal reporting definitions to which long-term care facilities must adhere, as it is the only way to make comparisons across states. These limitations make it impossible to determine the accuracy of the data that facilities self-reported pursuant to the state and federal reporting requirements without further case review in collaboration with those reporting facilities.

Moreover, assessing the accuracy of self-reported data would require detailed information about every deceased resident of long-term care facility that is required to report, such as name, date of birth, and date of death. Under law, facilities are not required to report this data. And while MDHHS and facilities' staff prioritized patient care throughout the pandemic, MDHHS has worked with facilities when reporting irregularities have arisen.

The analysis relies heavily on Michigan Disease Surveillance System data despite MDHHS's noted concerns that this system is not an appropriate source for determining if a COVID-19 case resulting in death should be counted as a death in a long-term care facility

We appreciate that your letter acknowledges our disagreement over the use of MDSS to count long term care COVID-19 deaths. We request that, instead of including a summary of our concerns, you include MDHHS's account of why the Michigan Disease Surveillance System is not an appropriate data source for the purposes of this analysis. Explaining the limitations is imperative for such a review and it is important that these points are not lost. A full response is something that you ordinarily afford departments and agencies when conducting a review.

The Michigan Disease Surveillance System is a tool designed for surveillance to enable contact tracing and disease exposure notification. The data comes from multiple sources and is manually entered and updated during public health investigations.

While we have attempted to make use of the capabilities of the Michigan Disease Surveillance System to the best of our ability during this public health crisis, we know that it is not an appropriate source for tracking if a confirmed or suspected COVID-19 case in the system is also a deceased individual who meets the requirements of a reportable long-term care COVID-19 case. The limitations with using data from the system to track this type of investigation is the reason MDHHS did not make use of it for identifying the number of long-term care facility deaths.

- ACCURACY OF CHECK BOX: The Michigan Disease Surveillance System long-term care facility variable is completed by local health jurisdictions during public health investigations. The case investigator may not be accurate in their assessment of what is a skilled nursing facility compared to an assisted living facility or other facility. The check box data are not validated to determine the accuracy of the determination of skilled nursing facility designation by the case investigator.
- DIFFICULTY IN MATCHING ADDRESSES: The address data associated with cases in the system are entered as free text, rather than in standardized fields, which makes matching addresses to specific facilities very challenging. This surveillance system is simply an outdated, clunky platform that we've continued to utilize for tracking reportable conditions because we have been unable to upgrade and replace it. Attempting to match

address data in real time during a pandemic is very different than a retrospective review of addresses.

- ACCURACY OF ADDRESSES IN MDSS: The addresses associated with cases in they system come into it via electronic laboratory report, to route the case to the appropriate local health jurisdiction for case investigation. The address on the lab results may be incomplete and can be the address of a provider or the address of a patient residence. The address could represent testing of a visitor to the facility. Some cases have multiple addresses, which are added as more information becomes available. Old address information would not be deleted in this circumstance.

- CONTINUING CARE RETIREMENT COMMUNITIES: Skilled nursing facilities may be part of complexes including other service types. The address that matches a skilled nursing facility may also be the same address as a hospice, assisted living facility or other residential setting. The case information in the system is not routinely validated against patient charts to determine which type of facility the patient was living in when they experienced COVID.

- TIMING OF INFECTION: The use of addresses in the Michigan Disease Surveillance System will not reflect if the patient contracted infection in the hospital. As such, the address of patients who are residents of skilled nursing may reflect their residential address, even if they were not infected at that facility. A full case investigation to understand timing of symptom onset and exposures at the facility and the hospital would be needed to understand where the infection was contracted. For most cases, that level of detail is not available in this system.

The analysis combines COVID-19 deaths in facilities that were required to report and those that were not required to report, creating the impression of a larger undercount by long-term care facilities than is warranted

The data table in section 2 is misleading and appears to suggest that there was a nearly 30% underreporting, when ***almost half of this difference can be attributed to facilities not subject to reporting requirements***. Further, those facilities that were not subject to reporting were beyond the scope of the request from the Legislature, much less the CDC, which set requirements at the federal level.

At a minimum, this section should be presented in two tables—one with the facilities subject to reporting and one with those who were not. Nevertheless, the best approach would be to narrow the data presented in the table to those facilities that were required to report. The narrative that follows could note that an additional 1,036 deaths were identified when your team looked across all long-term care facilities rather than limiting the scope to facilities subject to state and/or federal reporting requirements.

Lastly, if the assisted living category remains in the “required to report” category, the footnote should indicate that reporting requirements were not enforced and then rescinded in October 2020 due to the challenges you have noted in your report.

Finally, I would welcome your partnership in calling for legislative action to improve data collection and reporting in the future by investing in public health infrastructure.

- Our ability to upgrade and maintain data collection platforms is vital in being able to collect, analyze, and report accurate information during times of emergency or urgency. Clearly, our data platforms are outdated as all verification methods identified rely on manual data entry. Additional investment in our state public health data platforms is essential for us to provide this information quickly and transparently to the public.
- Further, health care facilities in Michigan are not required to regularly report pertinent public health data. Consistent collection of public health data from providers would improve the efficacy and efficiency of data reporting. Because no reporting requirements exist in law, an emergency order was required to compel reporting followed by education and training to bring facilities up to speed on reporting requirements. Any statutory requirements for minimum reporting from health providers would better position the state to respond to emergent public health crises.

Again, thank you for your partnership throughout this process.