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Joint Oversight Hearing

Assembly Health and Aging & Long-Term Care Committees

The Covid-19 outbreak in Skilled Nursing Facilities and the State's Response: A discussion of what has worked, what has not, and what are plans for the future?
Tuesday, June 9, 2020. 10:00 a.m. – 12:00 p.m.
State Capitol, Assembly Chambers

BACKGROUND

INTRODUCTION

This hearing is intended to provide an overview of the state's response to the "severe acute respiratory syndrome coronavirus 2" (COVID-19) outbreak in skilled nursing facilities (SNFs), primarily, the effect the disease has had on residents and their families. Patient advocates, state regulators, and industry members will provide testimony and engage in a roundtable discussion regarding what has worked, what has not, and what plans there are for the future, to enhance and improve the COVID-19 response in SNFs.

BACKGROUND

SNFs. In California, SNFs are licensed and regulated by the Department of Public Health (DPH) and provide skilled nursing and supportive care to patients whose primary need is for the availability of skilled nursing care on an extended basis. DPH is responsible for ensuring SNFs comply with state laws and regulations. DPH Licensing & Certification staff conducts approximately 1,320 on-site inspections of long-term care (LTC) facilities (including California's 1224 SNFs) and responds to approximately 6,650 complaints and 19,300 events reported by facilities each year. Events that facilities are required to report to DPH (reportable events) include interruptions of services essential to the health and safety of residents; alleged or

suspected abuse; all fires, disasters, and other risks to resident life or health resulting from accidents or incidents at the facility; and, administrator or director of nursing personnel changes. Investigation of complaints and reportable events also require on-site inspections. These inspections, called surveys, evaluate compliance with both state and federal requirements.

DPH requires LTC facilities to correct less serious deficiencies by implementing a written plan of correction without incurring fines or other penalties. If warranted, DPH may impose a fine, appoint a temporary manager or receiver, suspend or revoke the facility's license, or use other remedies for violations as provided by state or federal law. State law categorizes citations that impose a civil monetary penalty as Class B, A, or AA. The associated fines range from $100 to $1,000 for Class B; $5,000 to $20,000 for Class A; and, $25,000 to $100,000 for Class AA. The citation class and amount of the fine depends upon the significance and severity of the substantiated violation. Federal enforcement remedies include a written plan of correction, directed training, state monitoring, denial of payment for new admissions, ban on admissions, and fines ranging from $50 to $10,000 per day for survey violations and $1,000 to $10,000 for specific instance violations, such as a determination of immediate jeopardy or significant harm to the patient. While DPH can impose state fines, it can only recommend to the federal Centers for Medicare & Medicaid Services (CMS) that a federal remedy other than a written plan of correction be imposed. CMS may impose, modify, or waive DPH's recommended remedy.

Prior to the COVID-19 outbreak, all SNFs were required to have a staff member as a designated Infection Preventionist (IP); however, they are only mandated part-time, and generally have other full-time responsibilities. IPs are responsible for developing an infection prevention program that includes evidence-based practices to prevent healthcare-associated infections (HAIs) and provide safe, quality resident care. An infection prevention program should include policies and procedures that require the following:

1. Standard and transmission-based precautions;
2. Respiratory hygiene/cough etiquette;
3. Cleaning and disinfection of the environment and resident care equipment, including "who cleans what";
4. Use of Environmental Protection Agency-approved cleaning agents according to manufacturer instructions;
5. Evidence-based methods to prevent infection for residents with invasive devices such as urinary catheters, ventilators, or intravascular devices;
6. Vaccination for residents and health care personnel (HCP); and,
7. Screening and work restrictions to prevent HCP with a communicable illness from working with residents while ill or infected.

According to DPH's website, its Division of Communicable Disease Control (DCDC) works to promptly identify, prevent, and control infectious diseases that pose a threat to public

health. DPH works with local health officers (LHOs) to implement infectious disease control at the local level through the 61 legally-appointed physician LHOs in California, one from each of the 58 counties and the three cities of Berkeley, Long Beach, and Pasadena. DCDC identifies, prevents and controls infectious diseases that pose a threat to public health, including emerging and re-emerging infectious diseases, vaccine-preventable agents, bacterial toxins, bioterrorism, and pandemics. DCDC works with LHOs to identify and monitor reported cases of 90 reportable diseases, including recently added COVID-19. These reportable diseases and conditions are reported by health care providers and laboratories to LHOs, who then report this information to DPH.

In the case of a death due to a reportable disease, a physician or other person who has charge of a deceased person's body is required to call the coroner upon a death "known or suspected as due to contagious disease and constituting a public hazard." The coroner issues a tracking number as proof of the notification. The coroner decides whether to test the body and/or investigate the case. When the coroner's inquiry is over, the coroner is supposed to personally sign the death certificate, although if there's no doubt that the death was due to COVID-19, the coroner may choose not to investigate further and tell the physician over the phone that the coroner is delegating the duty to sign the death certificate to the physician. The coroner has to authorize the release of the decedent to the selected funeral home. The local registrar of births and deaths is not supposed to file the death certificate without the coroner's tracking number.

According to the DPH website, as of June 2, 2020, there have been a total of 5,746 confirmed COVID-19 cases in SNF HCPs, and 9,749 residents. There have been 52 HCP deaths, and 1,835 resident deaths.

COVID-19. COVID-19 is a viral respiratory illness caused by a new coronavirus. Coronaviruses are a large family of viruses that are common in people and many different species of animals, including camels, cattle, cats, and bats. COVID-19 was first reported in Wuhan, Hubei Province, China in November 2019. Over the next few months, the illness spread to almost every country. COVID-19 was declared a pandemic by the World Health Organization on March 11, 2020. COVID-19 can cause mild to severe illness; most severe illness occurs in adults 65 years and older and people of any age with serious underlying medical problems. On February 29, 2020, Washington State reported the first death in the U.S. from the new coronavirus, the first HCP to be infected with the disease; and most worrying, the first known outbreak in a SNF. The facility in Kirkland, Washington, reported that approximately 27 of the 108 residents and 25 of the 180 staff as having some symptoms. Due to the severity of the COVID-19 crisis, on March 4, 2020, Governor Newsom issued an Executive Order declaring a state of emergency and on March 19, 2020, issued a stay at home order.

According to the DPH website, as of June 2, 2020, there are a total of 115,310 positive cases and 4,286 fatalities in California. Over 40,000 of these cases are in individuals 50 years or older. Of the total COVID-related fatalities in the state, 1,835 (over 40%) have been SNF residents.

STATE'S RESPONSE TO COVID-19 IN SNFs

The state's public response to the COVID-19 outbreak began on January 23, 2020, with All Facility Letter (AFL) 20-09 from DPH, which provided information on COVID-19 and contained the latest Centers for Disease Control and Prevention (CDC) information, including infection control guidance, criteria for evaluation of patients, and recommendations for reporting, specimen collection, and testing. The letter states that as of that date, there were no confirmed cases of COVID-19 in California. According to DPH, on January 24, 2020, DPH activated a "medical action center," re-deploying 600 registered nurse surveyors from CMS facility licensing survey work, to provide technical assistance for infection control in SNFs.
Since March 2020, the state's focus has been preparing for a potential surge in COVID-19 cases, creating alternative care sites and increasing the number of hospital beds. "Flex" spaces, such as Sleep Train Arena in Sacramento, and the Los Angeles Surge Hospital (leased by the state on March 21, 2020) which were outfitted as temporary hospital spaces, should they be needed.

Additionally, in early March, DPH HAI teams began offering webinars for SNF staff to provide training on infection control, and on May 7, 2020, DPH began hosting weekly SNF Infection Prevention calls to discuss COVID-19 updates. The calls have focused on infection prevention guidance, and topics covered have included the importance of the IPs' communication with SNF administrators and nursing staff, the IPs' leadership role, the importance of handwashing, and assistance with developing COVID-19 mitigation plans.

In March, CMS also instructed SNFs to limit almost all visitors and the State Long Term Care Ombudsman ordered ombudsmen to refrain from providing in-person visits. According to the Long-Term Care Ombudsman Association, ombudsmen are still providing advocacy services, utilizing telephone, video/conference calls, virtual meetings, and email to "meet" with residents, residents' families and responsible parties, and facility administrators and staff. In addition, ombudsmen are conducting local community outreach events to educate the public regarding issues that affect care facility residents.

On May 8, 2020, CMS published an interim final rule requiring SNFs to report COVID-19 facility data to the CDC (via DPH), and, to notify residents, residents' representatives, and families of residents of when there are COVID-19 positive residents or HCPs in the facility. The report must include, but is not limited to, the following:

1. Suspected and confirmed COVID-19 infections among residents and staff, including residents previously treated for COVID-19;
2. Total deaths and COVID-19 deaths among residents and staff;
3. Personal protective equipment (PPE) and hand hygiene supplies in the facility;
4. Ventilator capacity and supplies in the facility;
5. Resident beds and census;
6. Access to COVID-19 testing while the resident is in the facility;
7. Staff shortages; and,

8. Other information specified by the Secretary of the Health and Human Services Agency (HHS).

Beginning May 14, 2020, SNFs must directly report the information above to DPH daily, via the SNF COVID-19 Survey no later than 12:00 P.M. Pacific Standard Time. DPH then reports this information to the CDC. According to DPH, this is a new system for these facilities, and while compliance is overwhelming, participation rates are not 100% every day, leading to some fluctuations in the data.

COVID-19 Mitigation Plan Requirements. On May 11, 2020, DPH issued AFL 20-52, advising SNFs of the requirement to submit a facility specific COVID-19 mitigation plan to DPH within 21 calendar days (June 1, 2020). Subsequently, AFL 20-53 provided updated infection control guidance for HCP. The mitigation plan must include the following six elements:

1. **Testing and Cohorting**. The SNF will develop a plan in conjunction with DPH and its local health department (LHD) for regular testing of residents and staff, including how test results will be used to inform resident and HCP cohorting;
2. **Infection Prevention and Control**. SNFs must now have a full-time, dedicated IP. This can be achieved by more than one staff member sharing this role, but a plan must be in place for infection prevention quality control. DPH's HAI Program has developed training materials for SNF IP staff. The SNF must ensure HCPs receive infection prevention and control training and can work with DPH to develop a reasonable implementation timeline and plan to bring on the necessary IP staff;
3. **PPE**. The SNF must have a plan for adequate provision of PPE, including types that will be kept in stock, duration the stock is expected to last, and information on established contracts or relationships with vendors for replenishing stock;
4. **Staffing Shortages**. The SNF must have policies in place to address HCP shortages, including contingency and crisis capacity strategies;
5. **Designation of Space**. The SNF must have policies in place for dedicated spaces within the facility to ensure separation of infected patients and for eliminating movement of HCP among those spaces to minimize transmission risk. In the event the facility cannot designate space, they are to communicate the limitation to their local public health department and DPH Licensing district office; and,
6. **Communication**. A designated staff member must be assigned responsibility for daily communications with staff, residents, and their families regarding the status and impact of COVID-19 in the facility.

AFL 20-52 states that each facility will receive a visit from DPH to validate its certification at least every six to eight weeks. If DPH determines that a facility is not implementing its approved mitigation plan and identifies unsafe practices that have or are likely to cause harm to patients, DPH may take enforcement action including calling for an immediate jeopardy situation which may result in a civil penalty.

AFL 20-52 also notes that Polymerase Chain Reaction (PCR) testing to detect COVID-19 infection is becoming more readily available at hospitals, academic, commercial, and public health laboratories across California and, if necessary, DPH can assist facilities with acquiring access to testing.

PPE. AFL 20-52 states that cloth face coverings may be worn in the facility by patients and the limited number of allowable visitors but should not be considered PPE for HCP because their capability to protect HCP is unknown and they should not be worn in lieu of a respirator or facemask during the provision of patient care. AFL 20-52 instructs HCP to continue to wear their respirator or facemask (implementing extended use) while in the healthcare facility instead of intermittently switching back to their cloth face covering, possibly causing self-contamination. HCP should remove their respirator or facemask and put on their cloth face covering when leaving the facility at the end of their shift. AFL 20-52 also notes that visitors and patients should be wearing their own cloth face covering upon arrival to the facility per CDC recommendations. AFL 20-52 states that this recommendation does not change CDC's guidance for HCP to use N95 or equivalent respirators when providing care for patients with suspected or known COVID-19 infection.

Facilities that do not have sufficient supplies of N95s or equivalent respirators are instructed to prioritize their use for activities and procedures that pose high risks of generating infectious aerosols, using facemasks for care that does not involve those activities or procedures. Once an adequate availability of supplies is reestablished, the guidance states that N95s and equivalent respirators use should resume for all HCP caring for these patients.

Staffing Requirements. AFL 20-52 also addresses contingency and crisis strategies to address staffing shortages, referencing CDC-released guidance on mitigating HCP staffing shortages for healthcare facilities experiencing staffing shortages due to HCP exposures, illness, or need to care for family members at home. The CDC guidance includes contingency and crisis capacity strategies that healthcare systems and facilities can consider in coordination with their LHDs. AFL 20-52 states that SNFs should plan for implementing contingency capacity strategies when anticipating staffing shortages, including, but not limited to, the following:

1. Determining the minimum number of staff needed to provide a safe work environment and patient care;
2. Identifying additional HCP to work in the facility pursuant to state emergency waivers or changes in licensing or certification requirements;
3. Contacting the Medical Heath Coordination Center call-in line for immediate staffing needs. All facilities must report directly to the coordination center before proceeding to evacuation;
4. SNF will provide DPH District Office with list of available positions they are hiring for and DPH may assist in connecting with available HCPs in the area;

5. DPH will work with SNFs to address social factors that might prevent HCP from reporting to work such as transportation or housing if HCP live with vulnerable individuals and provide the SNF with any available solutions for the geographic area; and,
6. Developing plans to allow asymptomatic HCP who have had an unprotected exposure to COVID-19 to continue to work under specified conditions.

Finally, AFL 20-52 notes that facilities should also be aware of and engage in regional planning efforts to transfer residents with COVID-19 to designated healthcare facilities, isolation sites or alternate care sites with adequate staffing.

Testing. On April 4, 2020, Governor Newsom announced the COVID-19 Testing Task Force, a public-private collaboration to boost California's testing capacity. The Task Force's stated goals are as follows:

1. Ensuring California has lab capacity to rapidly turn around test results and increase capacity strategically to meet demand;
2. Improving the supply chain to ensure that California can both collect samples and evaluate results without delay;
3. Enabling new, high-quality tests to launch in California as soon as possible;
4. Improving the ability to accurately track and evaluate COVID-19 testing capacity, results and reporting; and,
5. Building the workforce necessary to meet testing goals.

On May 22, 2020, DPH issued AFL 20-53 to all SNFs, which provided additional recommendations for developing the COVID-19 Mitigation Plans, including recommending baseline, surveillance and response-driven testing of SNF residents and HCP to prevent the spread of infection in the facility as follows:

1. Baseline testing for all SNF residents and HCP for any facility that does not currently have a positive case;
2. Testing residents prior to admission or readmission, including transfers from hospitals or other healthcare facilities. If the hospital does not test the patient, the SNF must test and quarantine upon admission;
3. Residents admitted from the hospital should be tested prior to admission and if they test negative should be quarantined for 14 days and then retested. If negative, the resident can be released from quarantine;
4. Testing of symptomatic or exposed residents;
5. An arrangement with laboratories to process tests. The test used should be able to detect SARS-CoV-2 virus (e.g., PCR) with greater than 95% sensitivity, greater than 90% specificity, with results obtained rapidly (e.g., within 48 hours). Antibody test results

should not be used to diagnose someone with an active SARS-CoV-2 (the virus that causes COVID-19) infection;

6. A procedure for addressing residents or staff who decline or are unable to be tested (e.g., if a symptomatic resident refuses testing in a facility with positive COVID-19 cases, they should be treated as positive);
7. Plans for use and follow-up of test results, including:
    a. How results will be explained to the resident or HCP;
    b. How to communicate information about any positive cases of residents or HCP in the facility to family members or responsible parties;
    c. How results (positive or negative) will be tracked for residents and HCP at the facility, and methods for communication of facility results with the local health department;
    d. How results will be used to guide implementation of infection control measures, resident placement, and HCP and resident cohorting;
    e. How results will be communicated to ensure appropriate management when residents are transferred to other congregate settings;
    f. Plans for serial retesting of residents and HCP who test negative and are still within 14 days of their last exposure to a positive resident or HCP in the facility; and,
    g. Plans to address potential staffing shortages if positive HCP are excluded from work.

According to the Testing Taskforce website, priority for who is tested is as follows:

1. Hospitalized patients;
2. Symptomatic and asymptomatic HCPs, first responders, and other social service employees;
3. Symptomatic and asymptomatic persons over 65 years of age or any age with chronic medical conditions that increase the risk of severe COVID 19 illness;
4. Persons identified for testing by public health contact investigations and disease control activities in high-risk settings;
5. Screening of asymptomatic residents or employees of congregate living facilities including:
    a. After positive cases have been identified in a facility; and,
    b. Prior to resident admission or re-admission to a facility.
6. Symptomatic and asymptomatic persons in essential occupations (e.g., utility workers, grocery store workers, food supply workers, other public employees); and,

7. Lower risk symptomatic persons.

A May 12, 2020, *CalMatters* article highlighted the lack of available testing to identify COVID-positive patients and staff in SNFs. Dr. Mehrdad Ayati, a geriatrician who teaches at Stanford University's School of Medicine was quoted in the article as saying, "When you see the mortality rates around the world; the population that we need to do massive testing in is residents and health care workerss in skilled nursing facilities."

Racial disparities. As noted on the DPH COVID-19 web page, the differences in health outcomes related to COVID-19 are most stark in COVID-19 deaths. With nearly complete data on race and ethnicity for COVID-19 deaths, trends are clearly emerging. Overall, for adults 18 and older, Latinos, African Americans, and Native Hawaiians and Pacific Islanders are dying at disproportionately higher levels. The proportion of COVID-19 deaths in African Americans is approximately double their population representation across all adult age categories. For Native Hawaiians and Pacific Islanders, overall numbers are low, but there is a four-fold difference between the proportion of COVID-19 deaths and their population representation. According to a May 28, 2020 California Health Care Foundation Report, "How California Can Advance Health Equity in the COVID-19 Era," this pattern also holds true in SNFs. Those with more than 25% Black and Latino residents are more than twice as likely to have at least one COVID-19 case as SNFs with less than 5% Black and Latino residents, regardless of location, size, or quality rating.

There has been little discussion on how to resolve the issue of health disparities with respect to the COVID-19 outbreak.

RECENT FEDERAL ACTION. On May 22, 2020, HHS announced a $4.9 billion targeted distribution from the Provider Relief Fund (PRF) to SNFs. Approximately $98 billion of the PRF remains for future distributions. HHS has not yet provided details about how these allocations will be made, but HHS has about $23 billion remaining for additional, targeted distributions. HHS details that each certified SNF with six or more beds will receive $50,000, plus $2,500 per bed. HHS notes that the additional funds are intended to help SNFs address critical needs such as labor, scaling up testing capacity, acquiring PPE, and other expenses related to the pandemic. SNF recipients must attest that they will only use the PRF payments for permissible purposes.

On June 1, 2020, CMS announced new enforcement actions it will take against SNFs in an effort to address the spread of COVID-19. CMS states that, of the roughly 80% of facilities that have complied with CDC reporting requirements, facilities have reported approximately 60,000 COVID-19 cases and nearly 26,000 deaths. Of those facilities that have reported the required data, approximately 25% reported at least one confirmed case of COVID-19, with 20% reporting at least one COVID-19-related fatality. CMS further found that lower quality ratings were associated with higher rates of infection in a facility. In response to these trends, CMS will leverage potential reductions in funding for states to drive 100% compliance with focused infection control SNF surveys.

CMS reports that states on average have completed 54.1% of the required number of focused infection control nursing home surveys. To increase compliance, CMS will require states to

submit a corrective action plan (CAP) to the agency if a state has not completed 100% of these nursing home surveys by July 31, 2020. The CAP must specify how a state will meet this 100% mark within a 30-day period. If a state has still not met the 100% mark during this 30-day period, CMS will reduce the state's CARES Act funding allocation by up to 10 percent. Failure to achieve a 100% survey rate after an additional 30-day period could result in funding reductions of an additional 5 percent. CMS states it will redistribute any withheld money to states that have successfully completed 100% of the required surveys.

According to CMS data, as of June 1, 2020, California has completed surveys of 94.7% of its SNFs.

CMS will also implement new penalties on SNFs that exhibit any deficiencies associated with infection control requirements. The severity of the penalties will increase in step with the level of deficiency. On the low end, a facility with an infection control deficiency that has not had a deficiency cited within the last year will be required to develop a *Directed Plan of Correction,* and in some cases may be subject to discretionary denial of new admissions with 45-days to rectify any infection control deficiencies. On the high end, a facility cited with infection control deficiencies at the immediate jeopardy level will be subject to Directed Plan of Correction requirements, denial of payment for new admissions, and will incur a civil monetary penalty. While CMS does not offer a range at this particular level of deficiency, CMS noted in other, less severe cases that facilities would be subject to penalty amounts of up to $20,000 per instance.

MOVING FORWARD. During a May 21, 2020 call with legislators, DPH outlined some early thoughts on how to respond to the COVID outbreaks in SNFs. Ideas included:

1. Developing a more targeted testing plan, focusing first on high-risk facilities;
2. Increasing the IP workforce in SNFs and the Public Health workforce;
3. Ongoing IP education of staff;
4. Changing the face of quality requirements by increasing the number of surveyors in facilities, and the frequency of inspections;
5. Increasing the state's access to real-time data by potentially developing a mobile app for surveyors enabling faster reporting of deficiencies; and,
6. Developing predictive analysis, potentially through the mobile app, to provide additional data to help predict where problems will arise.

While these ideas show a desire on the part of DPH to continue to improve the state's response to COVID-19 in SNFs, it is unclear how soon they could be implemented, if at all, especially given the state's current budget deficit. Additionally, the Governor's May Revision budget proposal to eliminate Adult Day Health Care/Community Based Adult Services (ADHC/CBAS) and the Multi-Purpose Senior Services Program (MSSP) could force this population into SNFs, increasing their risk of contracting COVID-19, as well as costs to the state.

The ADHC/CBAS and MSSP programs serve vulnerable seniors and people with disabilities who are at risk of institutional placement. Specifically, ADHC/CBAS is a community-based health program funded by Medi-Cal (with some private pay recipients) that provides health and social services to seniors and adults with disabilities who are at risk of institutional placement. ADHC/CBAS serves approximately 36,000 people, 34,679 of whom are Medi-Cal eligible. Participants in the program are individuals with Alzheimer's dementia, serious psychiatric disabilities, other cognitive disabilities and/or significant health issues such as heart disease, cancer or Parkinson's disease. Most participants require care and supervision by family members and other caregivers around the clock. ADHC/CBAS provides both the medical care and supports needed for these individuals to remain at home. The MSSP waiver program provides home and community-based services to Medi-Cal eligible individuals who are 65 years or older and have disabilities, as an alternative to nursing facility placement. MSSP serves approximately 12,000 low-income seniors, and provides community-based case management, linkages to other needed services, and can fund or purchase some services needed to help participants remain in their homes.

CONCLUSION.

Health outcomes are affected by many different forces including structural racism, poverty, and the disproportionate prevalence of underlying conditions such as asthma and heart disease among Latinos and African American Californians. When coupled with the increased risk of death from COVID-19 in those 65 and older, it is clear the state needs to do much more to protect its most vulnerable citizens. Until SNFs have adequate staff, PPE, and testing to protect residents, cutting programs like the MSSP, which state studies show saves us almost half the cost of nursing home care, seems penny-wise and pound-foolish.