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Testimony of the New York Civil Liberties Union

before

SENATE STANDING COMMITTEE ON HEALTH
SENATE STANDING COMMITTEE ON AGING
SENATE STANDING COMMITTEE ON INVESTIGATIONS AND GOVERNMENT OPERATIONS

and

ASSEMBLY STANDING COMMITTEE ON HEALTH
ASSEMBLY STANDING COMMITTEE ON AGING
ASSEMBLY STANDING COMMITTEE ON OVERSIGHT, ANALYSIS AND INVESTIGATION

Regarding

Residential health care facilities and COVID-19

August 10, 2020

The New York Civil Liberties Union (NYCLU) respectfully submits the following testimony regarding the disproportionate impact of COVID-19 on residential healthcare facilities and other long-term care settings, and solutions to mitigate that impact.

The NYCLU, the New York State affiliate of the American Civil Liberties Union, is a not-for-profit, nonpartisan organization with eight offices throughout the state and over 180,000 members and supporters. The NYCLU defends and promotes the fundamental principles and values embodied in the Bill of Rights, the U.S. Constitution, and the New York Constitution, including the right of every New Yorker to enjoy life, liberty, and equal protection under law. Our work includes defending the long-established rights of all New Yorkers to be free from discrimination on the basis of disability.

The NYCLU has long taken the position that segregated institutions are dangerous and unhealthy for both residents and staff, and the pandemic's impact on residential health care facilities reaffirms the wisdom of this stance.[1] This view applies with equal force to other congregate care

[1] The NYCLU is plaintiffs' counsel in the landmark *Willowbrook* case. *New York State Association for Retarded Children, et al. v. Cuomo, et al*, United States District Court for the Eastern District of New York, 72 Civ. 356, 357 (RJD). Well before the U.S. Supreme Court's decision *in Olmstead v. L.C.,* 527 U.S. 581 (1999), the *Willowbrook* consent judgment mandated that individuals with intellectual disabilities be afforded the "least restrictive and most normal living conditions possible." This represented a seismic move away from a medical model of care with a

settings — Individualized Residential Alternatives (IRAs) and Intermediate Care Facilities (ICFs) for people with developmental and intellectual disabilities certified by the New York Office for People with Developmental Disabilities (OPWDD), psychiatric hospitals and psychiatric institutions and community-based residential treatment facilities and other supportive group homes certified by the New York State Office of Mental Health (OMH) or the New York State Office of Addiction Services and Supports (OASAS). These are settings where workers' and residents' risk of infection and death are just as high as those in residential health care facilities but where we have insufficient data and other public reporting. Although we address the bulk of our comments to residential health care facilities, we urge these Committees to conduct similar oversight hearings with respect to the impact of COVID-19 in all congregate care residential settings in New York State.

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COVID-19 has raged through residential health care facilities and other congregate care facilities in New York State and continues to rage through residential health care facilities and other congregate care facilities across the country. Coronavirus cases have been reported in more than 15,000 residential health care facilities. Less than one-half of one percent of the U.S. population lives in a residential health care facility.[2] Yet, more than 335,000 residents and employees have been infected in those homes, and more than 59,000 have died. That means more than 40 percent of deaths from the virus in the United States have been tied to residential health care facilities and other long-term care facilities.[3]

According to the New York State Department of Health (DOH), as of July 30, 2020, there were approximately 6401 individuals who have died or are presumed to have died of COVID-19 who resided in residential health care facilities, not including adult care facilities, representing approximately 27% of the total COVID-19 fatalities to date in the state of New York. The DOH data is likely understated. The data is self-reported by residential health care facilities and that data has been incomplete or inaccurate in some cases. In turn, DOH's public reporting of fatalities has obscured the true scale of the pandemic's impact on the residents of these residential health care facilities because the official state nursing home death toll is an incomplete mix of confirmed-positive COVID patients who died, suspected COVID patients who died before they could be tested, those who died on-site and those who died after leaving the facility for hospital, home or hospice.[4]

Because of the intimate nature of the work required in these congregate settings — feeding, bathing, dressing, toileting — social distancing is impossible. As a result, frontline workers, who are disproportionately women of color and immigrants, are at high risk of contracting the coronavirus at

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robust focus on small community-based group homes, community inclusion, and true quality of life for people with I/DD.

[2] *See National Center for Health Statistics, HHS, Long-Term Care Providers and Services Users in the United States*, 2015-2016, at 76 (Feb. 2019) (identifying 1,347,600 nursing home residents in the United States in 2016), available at https://www.cdc.gov/nchs/data/series/sr_03/sr03_43-508.pdf; U.S. and World Population Clock, U.S. Census (calculating United States population as of Dec. 31, 2016 was 324,070,652), available at https://www.census.gov/popclock/.

[3] The New York Times, *Coronavirus in the U.S.: Latest Map and Case Count* (Updated July 28, 2020), https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html. The number reported includes some deaths at other long-term care facilities as reported by some states.

[4] *See* NY DOH, *Nursing Home and ACF COVID Related Deaths Statewide Data through July 30, 2020*,* available at https://www.health.ny.gov/statistics/diseases/covid-19/fatalities_nursing_home_acf.pdf.

work and spreading it within their families and communities. By the same token, infected frontline workers, who often work several jobs in multiple settings, may carry the virus from the community or from other congregate care settings to their workplace, leading to resident infection.

We have a responsibility to safeguard the health and safety of residents within institutional settings, to reduce the number of people in residential health care settings and other congregate care facilities for people with disabilities by transitioning them into community life, and to support and protect essential workers who care for seniors and people with disabilities regardless of setting. In order to achieve that critical transition from institutions to the community, New York State must also prioritize efforts to support and strengthen the workforce that sustains people with disabilities who rely on home and community-based services. These direct support professionals deserve better.

In this letter, we outline a series of steps that will help achieve these goals. We urge you to implement these actions as soon as possible.

A. Protect Residents in Residential Health Care Facilities and Other Congregate Care Facilities for People with Disabilities

1. Expand Data Collection and Transparency

We cannot prevail in the fight to control and limit COVID-19 infections and prevent deaths without accurate and comprehensive data about the full scope of the pandemic's reach and impact in New York State

As noted above, DOH's data on residential health care facilities is an incomplete mix of confirmed-positive COVID patients who died, suspected COVID patients who died before they could be tested, those who died on-site and those who died after leaving the facility for hospital, home or hospice. It was regrettable that DOH would not commit to data transparency at the August 3, 2020 hearing before your Committees.

The New York State Office for People with Developmental Disabilities does not publicly report its data[5] and releases a very limited set of data in stakeholder calls reflecting only the numbers of those people with IDD who are confirmed-positive COVID patients.[6]

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[5] OPWDD has directed its provider agencies to report to the New York State Justice Center or to OPWDD's Incident Management Unit for entry into OPWDD's Incident Report and Management Application (IRMA) all cases of confirmed COVID-19 and presumed COVID-19 cases, as well as deaths, occurring among individuals served by a provider and any staff member employed by a provider. https://files.constantcontact.com/5b48ae9f601/2189efe3-5aad-4dde-bcf6-073fd649893f.pdf. It has not released any of this information.

[6] The NYCLU has participated in the ongoing weekly COVID-19 stakeholders briefing call with the New York State Office for People with Developmental Disabilities ("OPWDD"). As of July 29, 2020, as of 7/29, 3427 New Yorkers with I/DD have had confirmed COVID-19. 2630 of these individuals live in OPWDD certified residential programs. 444 deaths attributable to confirmed cases of COVID-19 have occurred. 3859 staff working in OPWDD's certified residential programs have confirmed COVID-19.

A recent study published by researchers from SUNY Upstate Medical University and Syracuse University and shows that people with intellectual and developmental disabilities (IDD) are more likely to die from COVID-19 than those without I/DD. According to the researchers, the disparity is likely related to a higher prevalence of comorbid diseases among those with IDD, and/or a higher percentage of people with IDD are living in congregate residential settings. *See Intellectual and Developmental Disability and COVID-19 Case-Fatality Trends*, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7245650/. The study included 30,282 people who were identified as COVID-19 positive in the TriNetX COVID-19 Research Network Platform. People with IDD living in residential

The New York State Office of Mental Health also does not publicly report its data and it is unclear whether OMH releases any COVID-19-related mortality data to any stakeholders.[7]

The lack of data transparency across all New York State agencies providing certified services in congregate care settings is deeply troubling. We need data about all deaths and for all reasons from the start of the calendar year relating to COVID-19 infections and deaths in all congregate care facilities in New York State, including state-operated and private provider-operated group homes for people with I/DD, private and state psychiatric hospitals and supportive community-based housing, and all other Medicaid-funded congregate settings where older adults and people with disabilities live in order to allow researchers and members of the informed public to contribute insights and analysis to the state's effort to fight COVID-19.

We also take this opportunity to underscore the need for demographic information based on race and to highlight recent reporting showing that COVID-19 is more prevalent in residential health care facilities where residents are Black and Latinx. Those facilities— regardless of government rating, size or location — "were twice as likely to have adverse COVID-19 spread as those where the population is overwhelmingly white." [8]

Therefore, we urge you to ensure that all residential health care facilities are complying with required data collection but also to direct and assist all of the congregate care facilities for people with disabilities referenced above, *not just residential health care facilities*, to monitor and report to DOH, on a daily basis, information about testing, supplies of personal protective equipment (PPE), staffing levels, referrals and transfers to other facilities, positive cases and deaths of residents and workers in each facility. Data for all these facilities must be publicly available and posted on the DOH website, and include demographic breakdowns by race, gender, age, and disability.

2. Assure that All Residents and All Workers in All Settings are Tested for COVID-19

Both the CDC[9] and DOH[10] have issued testing guidance for long term care residential facilities. CDC has issued testing guidance that recommends testing of both residents and healthcare personnel

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group homes were at greater risk of severe COVID-19 outcomes: case rates - 7,841 per 100,000 for people with IDD compared to 1,910 for New York State; case-fatality - 15.0% for people with IDD compared to 7.9% for New York State; and mortality rate - 1,175 per 100,000 for people with IDD compared to 151 per 100,000 for New York State.

[7] The Greater New York Hospital Association ("GNYHA") reported in April, 2020 that The New York State Office of Mental Health (OMH) updated the New York State Incident Management and Reporting System (NIMRS) to include identification and tracking of COVID-19-related deaths. OMH further requests hospitals review all patient deaths dating back to March 1, 2020, and update all that are related or suspected to be related to COVID-19. The new COVID-19 category applies only to reporting patient deaths. *See OMH Incident Reporting and NIMRS COVID-19 Update,* available at https://www.gnyha.org/news/omh-incident-reporting-and-nimrs-covid-19-update/.

[8] The New York Times, *The Striking Racial Divide in How Covid-19 Has Hit Residential Health Care Facilities* (May 21, 2020), https://www.nytimes.com/article/coronavirus-nursing-homes-racial-disparity.html.

[9] See Testing Guidelines for Nursing Homes, Interim SARS-CoV-2 Testing Guidelines for Nursing Home Residents and Healthcare Personnel, updated July 21, 2020, available at https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html. The CDC notes this guidance is equally as applicable to other long-term care facilities (e.g., assisted living facilities, intermediate care facilities for individuals with intellectual disabilities, institutions for mental disease, and psychiatric residential treatment facilities).

[10] See Revised Interim Guidance: Protocol for Covid-19 Testing Applicable to All Health Care Providers and Local Health Departments dated July 2, 2020, available at https://coronavirus.health.ny.gov/system/files/documents/2020/07/doh_covid19_revisedtestingprotocol_070220.pdf

employed in long term care residential facilities. DOH's guidance, which follows Governor Cuomo's Executive Order 202.30 and 202.40,[11] is limited merely to periodic testing of healthcare personnel in long term care residential facilities, including adult care facilities.

"Cohorting" is a critical preventative safety measure mandated by DOH's May 13, 2020 guidance[12] and its April 29, 2020 guidance.[13] Separation of positive residents, referred to as "cohorting," decreases risk of transmission to negative residents. Cohorting allows dedicated staff to work only in the COVID-19-positive area so they are unlikely to carry the virus from positive to negative residents.

New York State must establish an ongoing COVID-19 viral testing program in all congregate care facilities for residents and staff alike at sufficient periodicity to rapidly identify asymptomatic, but contagious residents and staff. Viral testing of both staff and residents in congregate care facilities is an essential addition to other infection prevention and control recommendations aimed at preventing COVID-19 from entering these settings, detecting cases quickly, and stopping transmission. Serological (antibody) testing, which identifies who has been infected and recovered from COVID-19, may play a critical role in risk assessment and cohorting of residents.

Without mandating an ongoing testing regime for both staff and residents of long term care residential facilities, DOH has rendered its cohorting guidance meaningless.

3. Conduct an Independent Analysis of Why COVID-19 Ravaged New York's Residential Health Care Facilities

On or about July 6, 2020, in defense of its highly controversial policy to send COVID-19 positive patients from hospitals into nursing homes,[14] DOH issued a report concluding that the directive did not significantly contribute to the thousands of deaths that have occurred to date in residential health care facilities across the state.[15] The DOH report essentially absolved New York State of any blame;

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and Executive Order 2020.30 Nursing Home and Adult Care Facility Staff Testing Requirement FAQ updated June 24, 2020, available at https://coronavirus.health.ny.gov/system/files/documents/2020/06/nursinghome_stafftestingrequirementfaq_0624.pdf.

[11] See Executive Order 202.30, https://www.governor.ny.gov/news/no-20230-continuing-temporary-suspension-and-modification-laws-relating-disaster-emergency; Executive Order 202.40, available at https://www.governor.ny.gov/news/no-20240-continuing-temporary-suspension-and-modification-laws-relating-disaster-emergency.

[12] *See* NY DOH, Health Advisory: Nursing Home Cohorting FAQs, May 13, 2020, available at http://leadingageny.org/home/assets/File/5_13_20-DOH-Nursing_Home_Cohorting_FAQs.pdf.

[13] *See* NY DOH, Letter to Nursing Home Administrators, April 29, 2020, available at http://www.leadingageny.org/?LinkServID=27EEF181-F6B3-AAAD-C2EEE0328B2B821C.

[14] On March 25, 2020, Governor Cuomo, saying he feared that an onslaught of COVID victims would overwhelm hospitals, issued an order that effectively required nursing homes to accept COVID-19 patients being discharged from hospitals, so long as they were "medically stable." Under the policy, the nursing homes receiving the patients were barred from testing the patients to see if they might still be contagious. *See* March 25, 2020 *Advisory: Hospital Discharges and Admissions to Nursing Homes*, available at https://skillednursingnews.com/wp-content/uploads/sites/4/2020/03/DOH_COVID19__NHAdmissionsReadmissions__032520_1585166684475_0.pdf. Health experts, families of residents and nursing home operators objected to the mandate expressing concerns that the policy would needlessly lead to additional infections and deaths inside the homes. Governor Cuomo ultimately rescinded the policy on May 10, after more than 6,000 residents had died.

[15] *See Factors Associated with Nursing Home Infections and Fatalities in New York State During the COVID-19 Global Health Crisis*, revised July 20, 2020, available at https://health.ny.gov/press/releases/2020/docs/nh_factors_report.pdf.

the report concluded that "most patients admitted to nursing homes from hospitals were no longer contagious when admitted and therefore were not a source of infection." The report said that the disease was spread by "thousands of employees" and residents' families and other visitors who had the disease and did not know they were contagious.[16]

The tragic loss of life and the unnecessary spread of the virus between staff and residents at residential health care facilities requires an appropriately rigorous and independent outside investigation. That investigation must consider why these facilities lacked appropriate levels of staff and lacked access to appropriate personal protective equipment (PPE). The investigation must also consider DOH's longstanding failure, both pre-pandemic and during the pandemic, to assure these facilities maintain scrupulous compliance with infection control protocols.

4. Ensure Adequate Staffing Levels in Residential Care Facilities[17]

Residents of residential health care facilities require 24-hour monitoring and care. There are rigorous federal and state standards to ensure these residents are protected and receive the care and services they need to attain their highest practicable medical, emotional and social well-being. Appropriate staffing levels are the most important factor with respect to the safety and dignity of life experienced by the residents of residential health care facilities.

Every residential health care facility is required to have sufficient staff to ensure that each and every one of its residents receives the care and services to which they are entitled. New York State is one of the minority of states that fails to set minimum safe staffing requirements for its residential health care facilities. New York State is obligated to hold providers accountable when state surveyors identify low and insufficient staffing at residential health care facilities. In the absence of meaningful enforcement by New York State, including the imposition of monetary and other penalties for failures to meet staffing standards, most residential health care facilities operate with the lowest possible staffing levels.

The widespread failure to provide sufficient staffing, with the appropriate competencies, is responsible for the substandard services rendered in most [but not all] of New York's residential health care facilities. Pre-pandemic, Governor Cuomo indicated that he supported establishing safe

[16] DOH's report was apparently prepared with the aid of the consulting company McKinsey & Co. The report claims to draw from data collected from nursing homes through surveys. It does not list a single author by name, in or out of DOH. McKinsey itself is only listed in a footnote. The health department's website lists four independent reviewers, none of whom are epidemiologists. Two are hospital executives: Michael Dowling, the Northwell hospital chain CEO, and Dr. David L. Reich, president and chief operating officer of Mount Sinai Hospital.

[17] These Committees have received testimony from many residential health care facility advocates and front line workers in these settings supporting the Safe Staffing for Quality Care Act, A.2954/S.1032, available at https://www.nysenate.gov/legislation/bills/2019/a2954. This legislation would, for example, require acute care facilities and nursing homes to implement certain direct-care nurse to patient ratios in all nursing units; set minimum staffing requirements; require every such facility to submit a documented staffing plan to DOH on an annual basis and upon application for an operating certificate; require acute care facilities to maintain staffing records during all shifts; authorize nurses to refuse work assignments if the assignment exceeds the nurse's abilities or if minimum staffing is not present; require public access to documented staffing plans; impose civil penalties for violations of such provisions; and establish a private right of action for nurses discriminated against for refusing any illegal work assignment.

staffing levels to address longstanding deficiencies in the staffing levels at most residential health care facilities in New York State.[18]

The COVID-19 pandemic has torn back the curtain on the staffing deficiencies present in most of New York's residential health care facilities. Staffing standards are needed now more than ever to ensure protection from harm to residents of residential health care facilities.

5. Revoke completely Article 30-D of the Public Health Law immunizing residential health care facilities from liability

Article 30-D of the Public Health Law (Emergency Disaster Treatment Protection Act) was codified into law during the Fiscal Year 2021 budget under New York State Law by the Education, Labor and Family Assistance (ELFA) bill (A.9506/S.7506) at the behest of the Greater New York Hospital Association ("GNYHA") and by lobbyists on behalf of the residential health care facility industry.[19] Article 30-D instituted severe liability standards that essentially insulate nursing homes and their executive leadership from criminal or civil liability. Specifically, liability would only pertain to cases in which gross negligence, reckless misconduct, or instances where intentional malfeasance has occurred yet the law specified that those definitions do not apply to "decisions resulting from a resource or staffing shortage" as has been caused by the COVID-19 pandemic.

We know COVID-19 has grievously harmed, and continues to harm, residents and workers in residential health care facilities and other congregate care facilities in New York State. Longstanding problems— including living spaces that make distancing impossible, understaffing, poor infection control procedures, inadequate planning, and substandard care, along with more recent problems such as a lack of PPE— have contributed to the damage we are now witnessing. As noted previously, there is grave concern that these problems continue unabated in many of these facilities. Additionally, in most of these facilities, little is being done to reduce the census and instead we continue to see close, confined quarters, including two or more people living together in small rooms, congregate meals, and large numbers of residents sharing elevators and narrow stairways. Stripping residents and their family members of any ability to hold facilities accountable for the harm they have suffered under these circumstances is unconscionable.

Immunizing the business entities that operate residential health care facilities and other long-term care facilities will not only leave residents and their families with no recourse for serious harm or death, but will put more residents at risk and inevitably result in additional preventable resident deaths. The prospect of legal liability has served as a safeguard for the seniors and people with disabilities who live in skilled residential health care facilities, and other congregate care institutions by incentivizing these entities to provide quality care and comply with laws and regulations. Ensuring that residents and their family members can hold facilities accountable is even more important today because the individuals and agencies that typically provided some level of oversight

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[18] "We know that quality of care is directly linked to appropriate staffing levels." *See* June 22, 2018 Statement from Governor Andrew M. Cuomo, available at https://www.governor.ny.gov/news/statement-governor-andrew-m-cuomo-190.

[19] *See GNYGA Secures Immunity for Hospitals and Workers in Connection with COVID-19,* ML 48, April 2, 2020, available at https://www.thehealthworkforcehub.org/gnyha-secures-immunity-for-hospitals-and-workers-from-liability-in-connection-with-covid-19/. GNYHA has removed this press release from its website. *See also Nursing Homes are Hot Spots in the Crisis. But Don't Try Suing Them: In New York, 5300 nursing home residents have died of COVID-19. The nursing hone lobby pressed for a provision that makes it hard for their families to sue.* New York Times, May 13, 2020, available at https://www.nytimes.com/2020/05/13/nyregion/nursing-homes-coronavirus-new-york-html.

(e.g., family members, ombudsmen, protection and advocacy organizations) no longer have easy access to residents and facilities. To immunize institutions under these circumstances would be to abandon seniors and people with disabilities and to allow these institutions to neglect residents with impunity.

We are aware that Assembly Bill A10840/Senate Bill S8835 was enacted and signed into law just this week by Governor Cuomo. That legislation amends the immunity provisions that were enacted during the budget for healthcare facilities and professionals during the COVID-19 emergency. Immunity will now be limited to healthcare professionals providing diagnosis or treatment for confirmed and suspected COVID-19 patients and will not apply to prevention or the care of non-COVID patients or to hospitals for arranging healthcare services. While the legislation narrows the immunity coverage, it keeps the immunity law intact overall. The legislation specifies that the immunity applies to the "assessment or care" of a person with a suspected or confirmed case of the coronavirus. This legislation applies only prospectively to cases accruing after its enactment.

We urge you to repeal Public Health Law Article 30-D in its entirety.

B. Reduce the Number of People in Residential Health Care Facilities and Other Congregate Care Facilities for People with Disabilities

Given the longstanding obligation under the Supreme Court's *Olmstead* decision to move people from institutions to the community, and given the heightened public health hazard that these congregate settings are proving to be for residents and the workforce, New York State must undertake immediate efforts to reduce the number of people in long-term care facilities**.** New York State must:

1. Prioritize HCBS

New York State must prioritize and expand Medicaid-funded Home and Community-Based Services (HCBS) programs to help people with disabilities and seniors live in their homes and communities during, and after, the pandemic, rather than in more restrictive institutional. HCBS funds are necessary to sustain the workforce that supports people with disabilities, the service providers that employ that workforce, and the people with disabilities who rely on those services to live safely in their homes and communities. [20] New York State has sought approvals from CMS for section 1915(c) waiver Appendix K changes that have made it easier to access home and community-based services. Our state congressional delegation must be encouraged to support Federal Medical Assistance Percentage (FMAP) increases in the next COVID-19 relief package that Congress will likely pass, including an HCBS-specific FMAP increase in order to defray the cost of these programs and avoid cuts in the future and there should be no exemption afforded New York State from its Maintenance of Effort obligations to permit the state from implementing new Medicaid eligibility restrictions during the pandemic as a means to address the deep budget shortfalls confronting New York State.[21]

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[20] Steve Eiken et al., *Medicaid Expenditures for Long-Term Services and Supports in FY 2016,* Medicaid Innovation Accelerator Program (May 2018), https://www.medicaid.gov/sites/default/files/2019-12/ltssexpenditures2016.pdf.

[21] Letter from The Disability and Aging Collaborative & Consortium for Citizens with Disabilities to Sens. Mitch McConnell and Charles Schumer (June 15, 2020), *available at* http://www.c-c-d.org/fichiers/National-and-State-Sign-on-COVID-19-Senate-Letter.pdf. *See also Medicaid Maintenance of Effort Protections Crucial to Preserving*

2. Support Family Members Providing Care

Family caregivers play a central role in helping seniors and people with disabilities live in their homes and communities, rather than institutions. For instance, 80 percent of people with an intellectual or other developmental disability live with a caregiver who is a family member.[22] And more than 40 million family caregivers provide unpaid care each year.[23] But the economic, logistical, and health challenges faced by caregivers are only exacerbated by COVID-19, especially as infection spreads and creates new caregiving need. State Medicaid agencies can use emergency waivers or state plan authorities to permit family members or legally responsible individuals to be paid for providing state plan or HCBS services, and relaxing background checks and other onboarding requirements for family members.[24] Additionally, residents should be allowed to return to facilities if living conditions with their family members outside of congregate care settings become unsafe or unmanageable.

3. Assess the Status of Residents in Psychiatric Hospitals

Aggressive action is necessary to reduce the number of people confined in psychiatric hospitals. New York State should require psychiatric hospitals to certify and report immediately that they have engaged in an individualized assessment and re-evaluation of residents under their care in order to assess who can be discharged from the hospital and what supports are required to live in the community.

The federal government's Substance Abuse and Mental Health Services Administration (SAMHSA) has urged, with respect to admissions, that "[b]ecause of the substantial risk of coronavirus spread with congregation of individuals in a limited space such as in an inpatient or residential facility… outpatient treatment options [should] be used to the greatest extent possible. Inpatient facilities should be reserved for those for whom outpatient measures are not considered an adequate clinical option, i.e., for those with mental disorders that are life-threatening, (e.g., the severely depressed suicidal person)."[25] This standard must be applied in psychiatric centers until testing of patients and staff is widely done and safe isolation practices and social distancing protocols are in place.

Additionally, discharges should be accelerated.[26] To facilitate a decrease in the psychiatric inpatient population, states and localities should increase their support of community providers of

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Coverage, Center on Budget and Policy Priorities, May 13, 2020, https://www.cbpp.org/blog/medicaid-maintenance-of-effort-protections-crucial-to-preserving-coverage.

[22] The Arc, *New Data Reveals Our Nation Is Failing to Support People With Intellectual and Developmental Disabilities* (June 12, 2018), https://thearc.org/new-data-reveals-nation-failing-support-people-intellectual-developmental-disabilities/.

[23] National Council on Aging, *Issue Brief: Support Family Caregivers and Home and Community-Based Services* (March 2016), https://d2mkcg26uvg1cz.cloudfront.net/wp-content/uploads/IB16-Family-Caregivers-and-HCBS-March.pdf.

[24] Jessica Schubel, *States Are Leveraging Medicaid to Respond to COVID-19*, Center on Budget and Policy Priorities (Updated June 18, 2020), https://www.cbpp.org/research/health/states-are-leveraging-medicaid-to-respond-to-covid-19.

[25] Substance Abuse and Mental Health Services Administration, *Considerations for the Care and Treatment of Mental and Substance Use Disorders in the COVID-19 Epidemic* (March 20, 2020, revised May 7, 2020), https://www.samhsa.gov/sites/default/files/considerations-care-treatment-mental-substance-use-disorders-covid19.pdf.

[26] Ironically, many hospitals closed their psychiatric wards down during the early months of the pandemic in order to convert those beds to COVID-19 beds and appear to have no plans to reopen those wards to provide inpatient

outpatient mental health treatment. Restrictions on telemedicine have largely been lifted. However, community providers, already strapped before the pandemic, need greater funding and greater access to technology and personal protective equipment. Ensuring robust community-based crisis treatment, community supports, and integrated housing settings will reduce the need for psychiatric hospital admissions and enable more patients to safely return to their communities. In many cases, families will offer to temporarily house and care for relatives being discharged from or not admitted to hospitals. More will do so if support is available from community providers.

C. Support Direct Service Professionals and Workers in Congregate Facilities Who Care for Seniors and People With Disabilities

New York State must do all in its power to meet the needs of essential workers who, at great risk to themselves, their families, and their communities, are showing up every day to care for and assist vulnerable seniors and people with disabilities. Nearly 90 percent of nursing, psychiatric, and home care aides in the United States are women.[27] Black women are over-represented in the congregate care workforce,[28] and overall, the majority of women working as home health and personal care aides are women of color whose economic security is already precarious due, in part, to systemic racism that has long devalued caregiving[29] and fueled poverty-level wages.[30] All workers in the state deserve greater workplace benefits and protections but during this pandemic, the state should step forward and prioritize the needs of these essential workers.

1. Provide Personal Protective Equipment to Workers in All Settings

New York State must ensure that direct service professionals providing home and community-based services *and* workers in all congregate care facilities have the necessary supply of personal protective equipment including gowns, facemasks, gloves, hand sanitizers, and eye protection (i.e., face shields or goggles)(collectively "PPE). These workers must also be trained in appropriate utilization of PPE.[31] These Committees heard testimony from a variety of workers in New York's residential health care facilities about the dire shortages of PPE. The shortages experienced by

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psychiatric services. *See Many Psychiatric Units Went Offline During The Pandemic. Healthcare Workers Wonder If They'll Ever Return* , Gothamist, available at https://gothamist.com/news/many-psychiatric-units-went-offline-during-the-pandemic-healthcare-workers-wonder-if-theyll-ever-return. The individuals receiving services in those wards were transferred to institutional inpatient psychiatric services settings. It is unlikely that any of the funding for those hospital beds will be used to fund less restrictive community based services.

[27] AARP Public Policy Institute, *Women & Long-term Care (Fact Sheet),* Retrieved June 22, 2020, https://assets.aarp.org/rgcenter/il/fs77r_ltc.pdf.

[28] Timothy Bates et al., *Racial/Ethnic Diversity in the Long-term Care Workforce*, University of California San Francisco Health Workforce Research Center on Long-term Care (April 18, 2018), *available at* https://healthworkforce.ucsf.edu/sites/healthworkforce.ucsf.edu/files/REPORT-2018.HWRC_diversity_.4-18.pdf.

[29] Ariela M. Migdal, *Home Health Care Workers Aren't Guaranteed Minimum Wage or Overtime, and the Legacy of Slavery Is the Reason Why,* HuffPost (Updated May 6, 2016), https://www.huffpost.com/entry/home-health-care-workers_b_7224080?guccounter=1.

[30] Maya Raghu & Jasmine Tucker, *The Wage Gap Has Made Things Worse for Women on the Front Lines of COVID-19,* National Women's Law Center (March 30, 2020), https://nwlc.org/blog/the-wage-gap-has-made-things-worse-for-women-on-the-front-lines-of-covid-19/; Sarah True et al., *COVID-19 and Workers at Risk: Examining the Long-Term Care Workforce,* Kaiser Family Foundation (April 23, 2020), https://www.kff.org/medicaid/issue-brief/covid-19-and-workers-at-risk-examining-the-long-term-care-workforce/.

[31] Centers for Disease Control, *Preparing for COVID-19 in Residential health care facilities*, (Updated June 19, 2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html.

residential health care facilities have been well documented[32] but the situation facing workers in other settings was dire[33] and must be prioritized. Without innovative and aggressive action to procure PPE and improve utilization of PPE, seniors, people with disabilities, and workers who will be at risk and will die.

2. Increase Worker Pay and Provide Alternate Housing

New York State should increase workers' pay and offer alternative housing to workers, especially those in COVID-positive facilities, who don't want to return home and risk exposing their families to coronavirus. New York State should use Medicaid waivers or state plan authorities to pay overtime rates to workers at congregate care settings during this crisis as hazard pay or compensation for dangerous working conditions. We should also seek authorization for temporary supplemental pay increases to direct service professionals providing HCBS services and for overtime pay by lifting caps on the number of hours workers may provide HCBS services.

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New York State and our nation are facing unprecedented challenges. In this moment, we have been called to do battle not only against a pandemic that has taken the lives of many but also against long-entrenched biases that warehouse people with disabilities, and against systemic racism that has deeply wounded and killed more than we will ever know. In both instances, people with disabilities, Black people and other people of color have paid a steep price. But we can begin to strike a blow against these scourges by implementing the policy proposals outlined in this letter. These recommendations will not only help to safeguard the lives of seniors and people with disabilities, but also greatly benefit the Black and Brown workers (and their families) who comprise the majority of the workforce in long-term care facilities and HCBS programs.

Thank you for your consideration of our testimony.

[32] Jordan Rau, *Residential health care facilities Run Short Of COVID-19 Protective Gear As Federal Response Falters,* NPR (June 11, 2020), https://www.npr.org/sections/health-shots/2020/06/11/875335588/nursing-homes-run-short-of-covid-19-protective-gear-as-federal-response-falters.

[33] Alice Miranda Ollstein & Joanne Kenen, *Disabled, elderly going without home care amid shortage of protective gear and tests*, Politico (May 3, 2020), https://www.politico.com/news/2020/05/03/home-care-coronavirus-229723.