CONTINUING CARE LEADERSHIP COALITION CCLC

TESTIMONTY OF ROXANNE TENA-NELSON,

INTERIM PRESIDENT, CONTINUING CARE LEADERSHIP COALITION

JOINT LEGISLATIVE PUBLIC HEARING ON

LONG TERM CARE AND COVID-19

INTRODUCTION

I am Roxanne Tena-Nelson, Interim President, Continuing Care Leadership Coalition (CCLC), which represents not-for-profit and public long term care providers in the New York metropolitan area and beyond. Our members represent the full continuum of long term care, including skilled nursing and post-acute care, and a variety of home and community-based services. We appreciate the opportunity to provide testimony to the Senate and Assembly Committees on Health, Aging, and Investigations.

KEY POINTS

1. Our mission-driven members saved lives – thousands of lives, at least 3,200 – helping 74% of patients with COVID recover. It took a great deal of dedicated work that started long before COVID-19 came to New York, and that resulted from tirelessly answering the call of their missions each day.

2. Our members are essential to preparing for what comes next. The COVID-19 virus disproportionately came after our patients and the people who care for them, and long term care must be a central part of any preparedness planning we are doing right now. Managing the COVID-19 crisis has taken a toll on our members on many fronts, yet we can share many lessons learned and best practices from the experience this spring.

3. Our members need your support to continue their commitment to taking care of vulnerable older and disabled people. Long term care must not be viewed as a burden, but rather a critical piece of how we survive this pandemic. We must protect the financial and the psycho-social well-being of the long term care community to stabilize our health care system and remain ready to face any eventuality that may arise in the coming weeks and months.

HOW DID WE SAVE LIVES?

To validate the many anecdotal stories of how our members went above and beyond to care for their patients, we asked our members to tell us more about their experience this spring. Among CCLC member respondents, we found that the average facility had 74% of their patients recover from or return to home after having COVID illness. This represents more than 3,200 lives that our members helped recover. The following 2 factors are how our members saved lives:

We had a baseline of high performance. Long before the global community began detecting this novel virus, CCLC members have been focused on quality improvement, with a strong track record of high performance, investment in the workforce, and dedication to emergency preparedness. In Attachment 1, we demonstrate our members' baseline of high performance with a proven track record on quality measures for years, outperforming other facilities on State and Federal quality indicators. Under the quality measure portion of the State's rankings, 71% of CCLC members ranked in the top three tiers in comparison with just 59% of non-CCLC members; add in the other components[1], and 93% of CCLC members fall into the top three tiers, in comparison with other facilities at 59%.

Another contribution to high performance is our members' investment in their workforce. Our analysis of Federal payroll data demonstrates CCLC's disproportionate commitment to a highly qualified clinical staff, which has raised the bar for New York. Even beyond nurse staffing that is part of the quality rankings, the data in Attachment 2 shows that our members are more invested in medical services, demonstrated by a disproportionately higher level of attending physician care at 7.9 hours per resident per day, in comparison with other facilities that provide 0.8 hours, raising the State average up to 1.5 hours. Similarly, CCLC members provide a disproportionately higher investment in qualified licensed and registered staff reported in the Federal system, including staff such as advance practice nurses, social workers, and a range of therapists (see Attachment 2 for the full list of job categories for which CCLC members outperform others).

Additionally, CCLC has been deeply committed to emergency preparedness and response in the region, serving as the lead long term care contractor for a wide range of preparedness education and exercises. For example, CCLC in recent vintage has trained nearly 700 people through education sessions and forums, more than 400 people through tabletop exercises and surge test exercises, and fielded requests for more than a million pieces of PPE.

WHY ARE WE ESSENTIAL TO PREPARING FOR WHAT COMES NEXT?

We also did not shy away from finding solutions to the biggest challenges. Fighting this invisible virus was extremely difficult, especially during the months when scientists

[1] Including the State efficiency measure of potentially avoidable hospitalization (PAH) seen in Attachment 1, and other measures related to timely reporting.

did not yet know about asymptomatic infection. CCLC and our members took this challenge on in five main areas:

1. Sharing our expertise: CCLC coordinated with many partners by sharing information and best practices that emerged from the collective knowledge, creative problem-solving, and pure innovation of our members. For example on the Federal level, CMS included CCLC resources in the CMS Toolkit on state actions to mitigate COVID-19, highlighting member cohorting practices for residents receiving dialysis services, and infection control "strike teams" used during care transitions. On the State level, the State health department highlighted CCLC member solutions to communicating with families in April[2]. On the local level, for example, the New York City Office of Emergency Management and health department coordinated with CCLC, as the lead long term care convener playing a key role in: developing a health care workforce resource system; providing a feedback loop regarding personal protective equipment (PPE) needs; troubleshooting various issues, such as parking permits; and improving fatality management for long term care providers. With all of these experiences, it was important for CCLC to elevate long term care issues through various forums and to remain focused on solving a wide variety of problems effectively.
2. Supporting Creative Solutions: Due to the novel nature of the virus, and the unprecedented mandates, regulations, and guidance that descended upon the long term care provider community, CCLC needed to support all the creativity and ingenuity that our members and their staff could muster. CCLC members harnessed the creativity of their staff and created opportunities to engage their communities, including family and first responder car parades, walk-by or drive-by visits, regular family videoconferences, use of a robot for checking vital signs, robotic pet therapy, and variety of virtual offerings: music programming, at-home caregiver exercise classes, and religious services.
3. Focusing on Clinical Excellence and Testing: Although testing supplies were scant at the beginning of the COVID-19 emergency, several CCLC members prioritized virus testing for residents as early as they possibly could. Because such members had invested in strong clinical services, they were in a good position to undertake such efforts, so long as they could get the supply of testing kits and forge connections to lab services. When supplies were limited, members also encouraged testing of their staff at community testing sites, or otherwise. On May 10, the State staff testing mandate was a complicated endeavor, but CCLC members rose to the occasion, despite the incredible costs that have been incurred due to health plan denials of coverage for regular staff testing. CCLC members support testing to maintain infection prevention and control of the virus; however, they needed deeper governmental testing resourcing early on in the emergency, and they struggle to maintain workable testing programs with long wait times and the high financial burden, as the pandemic continues.

[2] See New York State Department of Health Dear Administrator Letter (DAL): C20-01, April 19, 2020.

4. Getting a Handle on PPE: CCLC members have acquired extensive experience and perspective in short order with the provision of PPE. During the global shortage, CCLC members exhausted all of their purchasing and supply chain opportunities, often going above and beyond to exceed Federal and State guidance to protect their staff. Some purchased items that are not considered PPE, such as head coverings requested by staff to help them feel safer. Regarding the building of reserves, CCLC supports all efforts to prioritize long term care providers as essential workers to gain access to PPE, and to avoid the missteps of underestimating the virus's impact on long term care patients and staff. CCLC learned that that PPE reserve policies must be practical for providers and account for uncertainties associated with pandemic circumstances, as well as other important factors: burn rates predicated on actual usage patterns; consideration of other health conditions occurring simultaneously with an ongoing pandemic; funding for PPE for a sector that has been stretched financially; considerations of storage costs and shelf-life limitations to ensure availability of fresh, unexpired equipment; adjustments to PPE typing based on developing science; recognition of marketplace volatility and its effects on access; and mapping the reach of the stockpiles crisply to define PPE needs of staff, residents, contractors, visitors, or other parties.
5. Building Capacities: One CCLC organization, for example, repurposed a closed facility on its campus, in partnership with its primary hospital transfer partner, to create a distinct space and workforce to care for COVID patients returning home to the facility, or in need of both convalescence and medically complex rehabilitation. Knowing their abilities to maintain safe environments focused on infection prevention and control, many other CCLC members supported the wider health care system to develop wings or units dedicated to COVID care, which employed structural modifications, workforce adjustments, procurement of PPE, a testing strategy, and care transition partnerships. In parallel, several answered the call in critical ways unique to COVID recovery – for instance accepting post-acute patients requiring ongoing ventilator support, tracheostomy care, dialysis services, and medically complex rehabilitation.

WHY DO WE NEED YORU SUPPORT?

First, our members face severe financial pressures exacerbated by COVID-19. Prior to the arrival of the virus, CCLC members were financially fragile; experiencing a $62 daily shortfall in Medicaid payments, margins that were at -5.2%, and for certified home health agencies, 78% of them operating in the red (2017 NYS Medicaid cost report data). Now that we endured this spring, we have learned that the biggest financial pressures are from decreased occupancy, a product of cancellations of elective and other surgeries and procedures in the acute care setting, and, after May 10, the State prohibition of COVID-positive patients being discharged from hospitals. In Attachment 3, CCLC members had occupancy rates above 90%, which has been the norm. In April 2020, occupancy rates dipped down to 76%; in May 2020, occupancy rates further dropped below 75%, and in

June 2020, occupancy rates dropped again to 61% for large facilities, and remained low for smaller facilities (75%). Our home care members also experienced analogous losses due to decreased visits.

Due to decreased occupancy, CCLC members have lost millions in revenue over the course of the pandemic, many of which have lost close to $2 million due to decreased occupancy alone with one facility reporting a loss of $5.6 million. Meanwhile, members have had to maintain the normal costs to maintain operations. Members also experienced other losses from suspending programs, such as adult day health care, and other long term care services and supports. In a preliminary look at CCLC member expenditures during the second quarter of 2020, CCLC found that most facilities spent more than $1.2 million, with some facilities spending close to $5 million on a variety of COVID-related expenses: PPE, mandated testing, additional staff, and workforce incentive payments and services. As July began and the threat continues, the losses and costs continue to mount.

Although the Federal government has allocated provider relief funding, the funds that came to long term care has been highly insufficient. For example, our members who disproportionately care for Medicaid beneficiaries[3], received less than 1% of the $50 billion general distribution of funds to providers, a pool of funds that tended to be more focused on Medicare providers. In fact, many CCLC members, were largely precluded from the Medicaid-focused relief funds, because they accepted even the smallest amount from the initial general distribution funds. Even if you factor in any additional targeted Federal funding, it does not come close to the losses described earlier, losses that continue each day going forward. One egregious example of this problem with the relief funds: a Medicaid-focused facility received approximately $2,500 of relief from the general distribution, incurred COVID-related expenses close to $1 million, and was precluded from seeking any more funding from the Medicaid relief pool.

Second, our members have had to navigate massive regulatory burdens. This spring, we juggled the fast-paced changing landscape of Federal, State, and local regulations and guidance that attempted to keep pace with the evolving knowledge of this novel virus, as seen in Attachment 4. Although some mandates may make public health sense, there are often unintended consequences that render the policy ineffective. One example is staff testing – something that we support in concept; the problem is that providers are collecting samples and waiting up to 12 days to get lab results, not to mention the high cost of this policy. Another example is the limited visitation policy, which requires 28 days without any residents and staff testing positive; the problem here is that the State's advisory is not aligned with the CMS guidance, which counts only facility-acquired infections, rendering visitation unachievable in the hardest hit neighborhoods in downstate New York. This is narrow interpretation is detrimental to the residents, as well as the families that want to see their loved ones. Indeed, the regulatory pressures have not stopped, as we seek to meet a new law on Pandemic Emergency Plans – requiring 60-day supplies of PPE, a

[3] Virtually all long term care providers in our State are "safety net" providers, insofar as they are deeply involved in serving the Medicaid-eligible population with fully 72% of all nursing home days of care, and 87% of all home care and personal care services, tied to serving Medicaid beneficiaries.

testing plan, among other items – and prepare for a potential resurgence of the virus. We would approach a resurgence this fall with many lessons learned, but we would face new challenges with the convergence of flu season, a new school year, and coastal storms.

Last but not least, a significant cost that has yet to be quantified is the mental health impact of the COVID-19 emergency on our sector. People who work in long term care have experienced tremendous amounts of stress stemming from the highly intense nature of this emergency, and the anxieties that came from actual infection or the fear: of getting infected, of infecting one's family, of the public turning against them, of being scrutinized by governmental authorities, of one's own mortality. CCLC recognizes that COVID-19 has had a major impact on the mental health of the long term care workforce, and providers will need assistance in addressing this serious issue.

We contend that we must meet these challenges head-on in order to maintain a strong, compassionate, and high-performing long term care community.

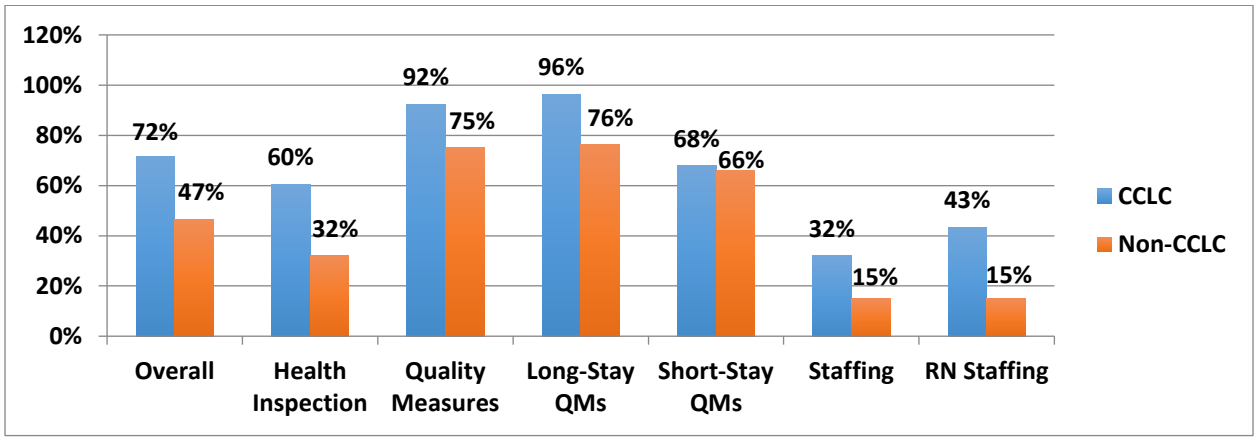
RECOMMENDATIONS

The following are our recommendations to prepare for the coming weeks and months:

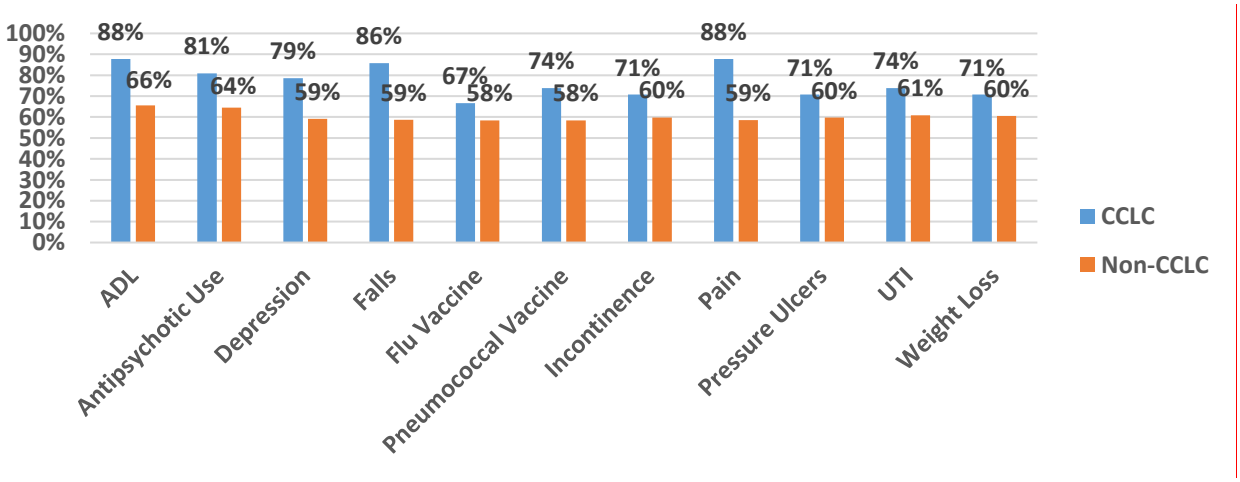
- Prioritize long term care for distribution of PPE preparing for a heightened emergency
- Prioritize long term care for on-going testing with workable turnaround times for quick results of less than weekly
- Provide strong financial support to long term care for PPE, for our workforce, and for testing
- Prioritize long term care for vaccination strategies that factor in cultural competency
- Maintain strong provider and staff liability protections for disasters and emergencies
- Thank the long term care community for what they have done and what they do every day to care for our most vulnerable New Yorkers

ATTACHMENT 1

CMS Five Star Rating: Process date - 4/1/20
Percentage of Nursing Homes Rated 4 and 5 Stars
(Higher is better)

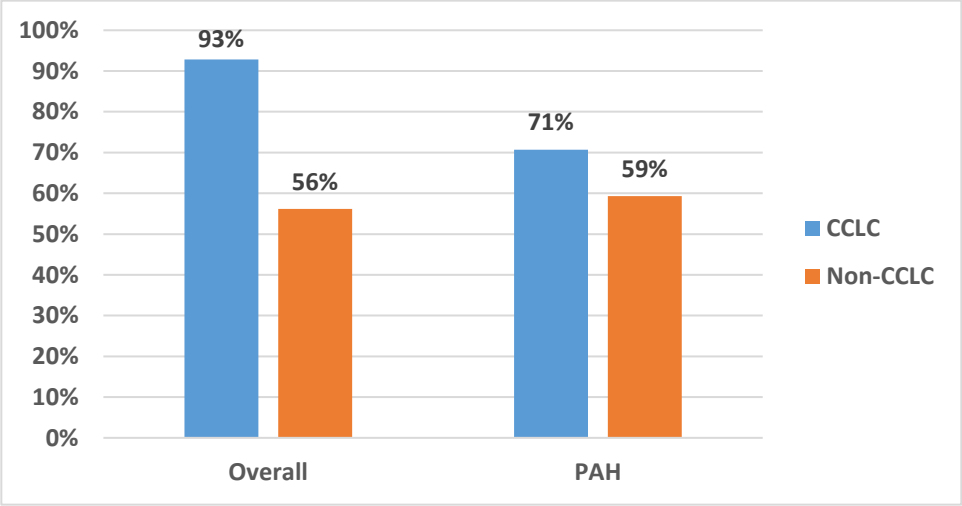


2018 NYS Nursing Home Quality Initiative (NHQI)
Percentage of Nursing Homes Ranked in the Top Three Quintiles
(Higher is better)



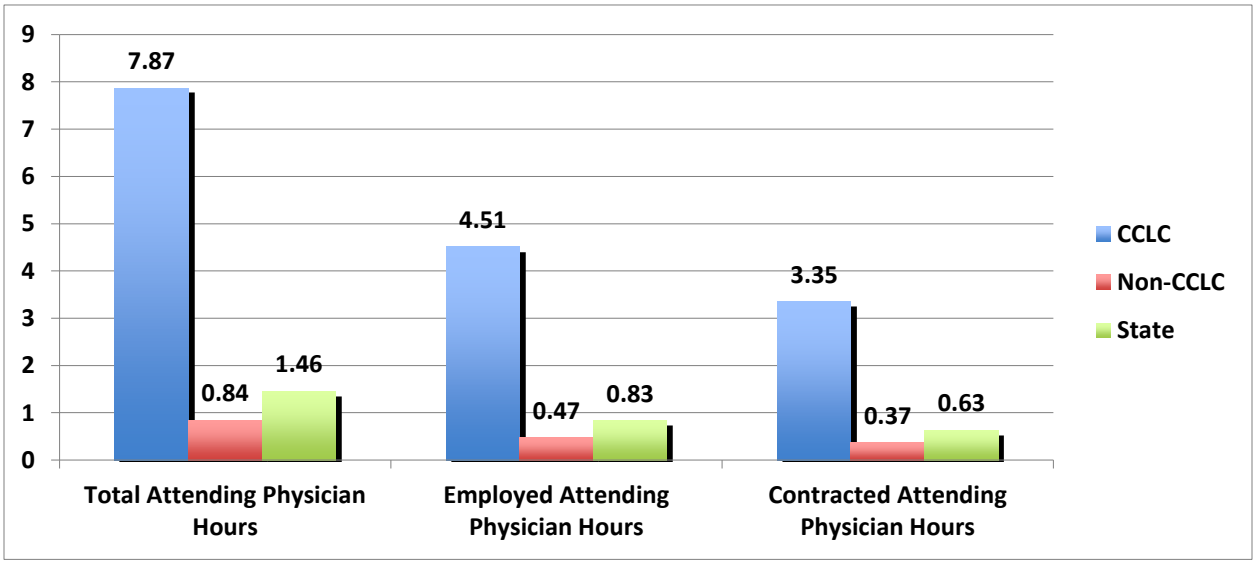
ATTACHMENT 1 (continued)

2018 NYS Nursing Home Quality Initiative (NHQI)
Percentage of Nursing Homes Ranked in the Top Three Quintiles:
Overall and Potentially Avoidable Hospitalizations (PAH)
(Higher is better)



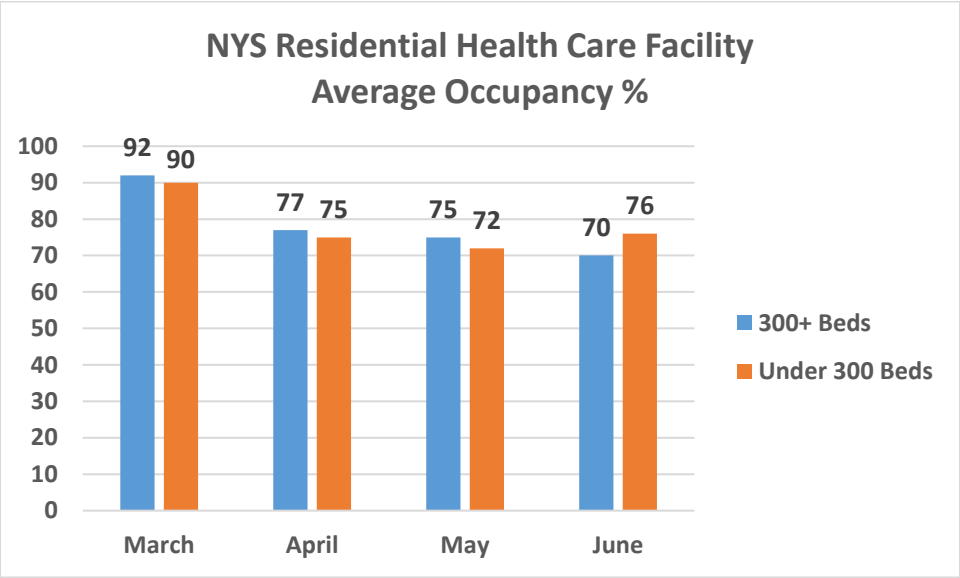
ATTACHMENT 2

Centers for Medicare and Medicaid Services
Payroll-Based Journal (PBJ) CY2019 Q4
Average Number of Hours/Resident/Day
(Higher is better)



Other Licensed or Registered Roles in PBJ Database: Medical Director, Physician Assistant, Nurse Practitioner, Pharmacist, Dietitian, Occupational Therapist, Physical Therapist, Speech/Language Pathologist, Respiratory Therapist, Therapeutic Recreation Specialist, and Qualified Social Worker.

ATTACHMENT 3



Source: Health Data NY: NH Weekly Bed Census

ATTACHMENT 4

(Non-Exhaustive) Timeline of COVID-19 Regulatory Activity Primarily Affecting Long Term Care

	CDC	CMS	DOH	NYS Executive
3/2020	**Guidance for Home Care, 3/10**	**Quality and Surveillance Changes, 3/23** **Approval of NYS Request for 1135 Flexibilities, 3/26**	**Guidance for Nursing Facilities, 3/11** **Closure of Adult Day Programs, 3/17** **Guidance for Community Based LTC, 3/18** **NYS DOH Guidance for Nursing Facilities, 3/21** **NYS DOH Visitor Restriction, 3/20** **NYS DOH Guidance for Home Care & Hospice, 3/22** **Directive on Hospital Discharges, 3/25** **Return to Work Guidance, 3/31**	
4/2020	**Guidance for Long Term Care, 4/30**	**Resident Transfer Scenarios, 4/13** **Facility Notification to CMS and Resident/Family Communication, 4/19** **Guidance on COVID-19 in Home Health Care, 4/23** **Memo on 5-star, staff data, FAQs, 4/24**	**NYS DOH Infection Prevention and Control Checklist, 4/10** **Resident and Family Communication, 4/4** **Resident and Family Communication, 4/19** **Dear Administrator Letter-Nursing Home Requirements-communication, 4/29** **Dear Administrator Letter-Return to Work, 4/29**	**Executive Order 202.18, 4/16** **Executive Order 202.19, 4/17**
5/2020	**CDC Infection Prevention**	**Interim Final Rule on Reporting, Enforcement,**	**Nursing Home Assistance and Coordination Center, 5/10**	**Executive Order 202.30, 5/10 (subsequently**

	and Control Tool, 5/8 **Infection and Prevention Guidance for Patients in Health Care Facilities, 5/18** **COVID-19 Guidance for Nursing Facilities, 5/19**	**Survey, Tags, and Transparency, 5/6** **Approval of NYS Request for 1135 Waivers, 5/6** **1135 Blanket Waivers, Updated 5/15** **Home Health Waivers, 5/15** **Long Term Care Facility Waivers, 5/15** **Reopening Recommendations, 5/18**	**FAQ Document, 5/12 (Revised 5/19)** **Directive on Staff Testing Medically Necessary, 5/19** **Dear Administrator Letter, Resident Deaths, 5/19** **Revised Certification of Compliance, 5/23**	**extended by EO 202.40 and EO 202.50)**
6/2020	**Updated LTC COVID-19 Preparedness Guidance, 6/25**	**CMS Enhanced Enforcement, 6/1** **Visitation FAQ, 6/23**		**Tri-state travel advisory: 14-day quarantine for travelers from states with significant community spread,6/24**
7/2020	**Updated Strategies for Optimizing PPE, 7/15** **Updated Return to Work Criteria, 7/17**		**Visitation for Nursing Facilities, Adult Care Facilities and Pediatric SNFs, 7/10**	