Informational Hearing
Senate Special Committee on Pandemic Emergency Response
Skilled Nursing Facilities during the COVID-19 Pandemic

Wednesday, June 10, 2020 at 9:00 a.m.
State Capitol, Senate Chamber

BACKGROUND PAPER

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Coronavirus Disease 2019 (COVID-19)

COVID-19 is a respiratory illness that can spread from person to person and it has been impacting countries around the world, starting at least as early as December 2019. According to the Centers for Disease Control and Prevention (CDC), symptoms of the coronavirus include fever, chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting and diarrhea. COVID-19 can be transmitted to others before any of these symptoms are apparent. Additionally, many of those who contract COVID-19 are asymptomatic, and yet are able to transmit the virus to others. Older adults and people who have severe underlying medical conditions like heart or lung disease or diabetes are at higher risk for developing more serious complications or dying from COVID-19.

COVID-19 Pandemic

The World Health Organization (WHO) declared COVID-19 a pandemic on March 11, 2020. On March 13, 2020, President Trump proclaimed that the COVID-19 outbreak in the United States constitutes a national emergency. The United States has by far the highest number of reported cases of COVID-19 in the world. Due to the severity of the COVID-19 crisis, on March 4, 2020, Governor Newsom issued an Executive Order declaring a state of emergency. On March 19, 2020, the Governor issued a statewide stay-at-home order.

According to tracking by the *New York Times*, as of June 3, 2020, the coronavirus pandemic has sickened more than 6.4 million people worldwide. More than 380,000 people have died in this

global outbreak. More than 1,841,400 people in the United States have been infected with COVID-19 and at least 106,100 have died.

Using data from June 6th, the California Department of Public Health (CDPH) reported 128,812 total cases of COVID-19 in California, more than twice as many cases as recorded a month earlier. As of June 1st, more than 2 million COVID-19 tests had been administered and run in California, with 1 million of those tests administered in the previous three weeks. The increase in cases reported over the last month is, in part, due to a significant increase in testing during that time period. At the beginning of the outbreak, even people who were symptomatic did not necessarily have access to testing, but there has been a steady increase in testing since then.

As of June 6th, there were 4,626 COVID-19 deaths reported in California, 2,620 of those deaths were in Los Angeles County. As of June 6th, there were 3,138 patients who tested positive for COVID-19 who were currently hospitalized in California and another 1,387 in the hospital who were suspected to have COVID-19. The state intensive care unit (ICU) figures as of June 6th were 1,068 patients who have tested positive in ICUs and another 220 patients in ICUs who are suspected to have COVID-19, which is a decrease from where we were one month earlier. As of June 6th, local health departments reported 11,062 confirmed positive cases in health care workers and 65 deaths statewide.

Skilled Nursing Facilities in California

A skilled nursing facility (SNF) is a health facility that provides skilled nursing care and supportive care to patients whose primary need is for the availability of skilled nursing care on an extended basis. Such care comprises 24-hour inpatient treatment, including physician, skilled nursing, dietary, pharmaceutical, and activity services. Most facilities serve the elderly, however some provide services to younger individuals with special needs, such as those with developmental or mental disabilities. SNFs serve the population identified as most at risk from COVID-19: the elderly and those with chronic conditions, including some with existing respiratory conditions.

The majority of SNF residents are seniors. In 2018, 78% of nursing home residents in California were over the age of 65. More than 57% of residents were at least 75 years old. Fifty-eight percent of residents were female. The percentage of residents who are white (which includes Hispanics) was 54.5% in 2018; Hispanics were 19.5% of residents; Blacks were 11.6% of residents; those who are API made up 12.6% of residents; Native American .5% and those of other or unknown races 20.8%.

Many nursing home stays are relatively short. Almost 85% of stays in 2018 were less than 3 months in duration, with some of the residents in nursing homes recovering from surgery or illness. Almost 10% of residents were in SNFs for 3 months to 1 year, 4.7% were there for 2-5 years and less than 1% of residents were there for more than 5 years.

According to the California Health and Human Services Agency, there are approximately 120,000 residents living in 1,224 SNFs in California. These SNFs are licensed by the CDPH, which is responsible for state oversight related to the care provided in these facilities. CDPH

conducts on-site inspections of SNFs, receives and responds to complaints and reportable events related to those facilities. CDPH may require corrective action plans, levy fines, suspend or revoke a SNF's license or utilize other remedies when violations of law occur. In 2019, Los Angeles County entered into a contract with CDPH that transferred the responsibility of health care facility investigation and monitoring activities to the County. Los Angeles is the only county that has this arrangement with CDPH.

According to a 2018 report about SNFs published by the Kaiser Family Foundation (KFF), 83.5% of the SNFs in California were for-profit, 12.6% nonprofit and 3% government run. At the time, 62% of the residents were covered by Medi-Cal, 14.5% Medicare, and 24% private pay. The KFF report also explains: "On average, in 2016, residents' level of need for assistance with activities of daily living scored 5.8 on a scale from 3 to 9, and levels of need have been fairly stable since 2009. Residents commonly have mobility impairments, which range from difficulty walking to inability to get oneself out of bed. While relatively few (4%) residents were bed-bound in 2016, over six in ten (65%) of residents depend on a wheelchair for mobility or are unable to walk without extensive or constant support from others."

At the request of the Legislature, the state auditor has conducted multiple audits related to the quality of care at California's Skilled Nursing Facilities in recent years. In the May 2018 audit report, the state auditor "concludes that the State has not adequately addressed ongoing deficiencies related to the quality of care that nursing facilities provide. From 2006 through 2015, the number of substandard care deficiencies that nursing facilities received increased by 31 percent." while "…deficiencies associated with nursing facility noncompliance that caused or were likely to cause, serious injury, harm, impairment, or death to residents increased by 35 percent from 46 in 2006 to 62 in 2015." The state auditor expressed concern that state penalties ultimately paid by the SNFs when citations were issued for deficiencies "may not create an adequate deterrent for nursing facilities providing substandard quality of care."

Number of cases of COVID-19 in SNFs and number of deaths

The COVID-19 pandemic has had a significant nationwide impact on residents and workers at skilled nursing facilities. One of the first major outbreaks reported in the U.S. occurred in a Washington State nursing home in February 2020.

The Centers for Medicare & Medicaid Services (CMS), an agency within the U.S. Department of Health and Human Services (HHS), is responsible for ensuring approximately 15,500 nursing homes nationwide meet federal quality standards to participate in the Medicare and Medicaid programs. CMS released data on June 4, 2020 indicating that at least 31,782 residents of nursing homes have died from COVID-19 in the United States, with at least 95,515 having contracted COVID-19 and an additional 58,288 who are suspected to have contracted COVID-19. Approximately 1 in 5 facilities nationally reported a COVID-19 death. This data does not capture all of the positive cases or deaths related to COVID-19 in U.S. nursing homes, in that 11.5% of the 15,000 skilled nursing facilities certified by CMS across the country had not yet reported data to CMS. The data includes deaths that occurred at nursing homes and those that occurred in other locations, such as a hospital or private home, if the death occurred within the

14-day bed hold period after the resident transferred from the skilled nursing home. Deaths that occurred outside of this 14-day period may not be captured.

According to June 6th data from CDPH, 10,308 nursing home residents tested positive for COVID-19 and 6,099 health care workers at SNFs tested positive. As of June 6th, a reported 1,958 nursing home residents have died from COVID-19 and 57 SNF health care workers have died. Based on those figures, at least 43.5% of those who have died from COVID-19 in California were residents or health care workers at SNFs.

In Los Angeles County, approximately 50% of those who have died from COVID-19 so far were residents or health care workers at SNFs. The Los Angeles Board of Supervisors passed a motion in late May that refers to SNFs as "the epicenter of the County's COVID-19 epidemic" and directs that an Inspector General be hired to provide a report on the oversight and operations of SNFs in the County. The motion also directs the County-Auditor/Controller to implement some transparency measures and directs county staff to "to ensure there is the necessary staffing, expertise, training, enforcement protocols, and other functions required to support this monitoring and enforcement effort."

State Response - California Department of Public Health

The state began taking action to prevent the spread of COVID-19 in California's SNFs before there were any known cases here. CDPH issued an All Facility Letter (AFL 20-09) on January 23, 2020 to health facilities (including SNFs) to provide basic information, including some of what was known about COVID-19 at the time, a reminder of infection control guidance, and basic procedures for symptomatic patients.

AFLs have been released by CDPH to facilities on an ongoing basis since late January. In March, CDPH offered webinars about infection prevention and control to SNF staff. By March 3rd, community transmission had been confirmed in California and CDPH issued interim guidance that included CDC guidelines healthcare facilities should follow to prepare for community transmission of COVID-19.

In April, Governor Newsom announced six indicators that would drive California's decision to gradually modify portions of the state's stay-at-home order. The first two of those indicators are both particularly relevant to residents in SNFs:

- Expanding testing and contact tracing to be able to identify and isolate those with the virus;
- Preventing infection in people who are most at risk;

On April 30th the California Department of Aging issued answers to commonly asked questions for friends and family with a loved one in a Skilled Nursing or Residential Care Facility for the Elderly, which is particularly important since family and friends cannot visit residents at this time. There are suggestions both for how to connect with a loved one during this time when you cannot be with them in person, and for getting information about what is happening at the facility and whether there are cases of COVID-19 there. Information about what actions the state is

taking to keep people in SNFs safe and how to file a complaint against a nursing home is also included.

It was not until May 11th that CDPH issued AFL 20-52, which required all SNFs to develop a plan in conjunction with CDPH and their local health department to expand their existing infection control policies to include the development and implementation of a CDPH approved COVID-19 mitigation plan. The mitigation plan must include the following six elements:

1. **Testing and Cohorting.** The SNF will develop a plan in conjunction with CDPH and their local health department (LHD) for regular testing of residents and staff, including how test results will be used to inform resident and healthcare personnel (HCP) cohorting.

2. **Infection Prevention and Control.** The SNF must have a full-time, dedicated Infection Preventionist (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. CDPH's Healthcare-Associated Infections Program has developed training materials for SNF IP staff. The SNF must ensure HCPs receive infection prevention and control training and can work with the department to develop a reasonable implementation timeline and plan to bring on the necessary IP staff.

3. **Personal Protective Equipment (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 CDPH Licensing district office.

6. **Communication.** A designated staff member has been assigned responsibility for daily communications with staff, residents, and their families regarding the status and impact of COVID-19 in the facility.

These mitigation plans from each SNF were required to be submitted to CDPH no later than June 1, 2020. According to the AFL, each facility will receive a visit from CDPH to validate its certification at least every six to eight weeks. If CDPH determines that facility is not implementing its approved mitigation plan and identifies unsafe practices that have or are likely to cause harm to patients, CDPH may take enforcement action, including calling an immediate jeopardy situation which may result in a civil penalty.

The Governor's May Revise budget proposal would eliminate funding for Adult Day Health Care/Community Based Adult Services (ADHC/CBAS) and the Multi-Purpose Senior Services Program (MSSP), which would likely increase the number of people who need nursing home care. The budget agreement announced on June 3rd between the two houses of the legislature rejects these cuts.

COVID-19 Testing

Broad access to polymerase chain reaction (PCR) diagnostic testing for COVID-19 and rapid results are vital for disease monitoring, rapid public health response, and disease control. At the start of the COVID-19 outbreak, widespread access to testing in the United States was hampered by supply shortages and other factors. Additionally, after testing samples are collected, they are sent to centralized laboratories for the actual testing. The amount of time it takes to obtain results has varied widely, from 12 hours to two weeks. Delay in receiving testing results necessitates infection prevention measures and containment measures until the results are known.

On April 4th, Governor Gavin Newsom announced the launch of California's COVID-19 Testing Task Force, with the mission of coordinating public and private sector efforts to significantly increase access to testing across California. The goals of the Testing Task Force include:

• Ensuring California has lab capacity to rapidly turn around test results and increase capacity strategically to meet demand;

• Improving the supply chain to ensure that California can both collect samples and evaluate results without delay;

• Enabling new, high-quality tests to launch in California as soon as possible;

• Improving our ability to accurately track and evaluate COVID-19 testing capacity, results and reporting; and

• Building the workforce necessary to meet our testing goals.

On April 30th, the CDPH issued new guidance on prioritization to expand access to COVID-19 testing.

Tier 1

Testing Modality: PCR with or without Serology

- Hospitalized patients
- Symptomatic and asymptomatic healthcare workers, first responders, and other social service employees
- Symptomatic and asymptomatic persons >65 years of age OR any age with chronic medical conditions that increase the risk of severe COVID 19 illness

- Persons identified for testing by public health contact investigations and disease control activities in high risk settings
- Screening of asymptomatic residents or employees of congregate living facilities including:
    - After positive cases have been identified in a facility
    - Prior to resident admission or re-admission to a facility
- Symptomatic and asymptomatic persons in essential occupations
    - E.g., utility workers, grocery store workers, food supply workers, other public employees
- Lower risk symptomatic persons

Tier 2

Testing Modality: PCR with or without Serology

- Lower risk asymptomatic persons

On May 12th, the Trump Administration recommended that all states test nursing home residents and staff members for the novel coronavirus over the next two weeks. The following day, the Newsom Administration acknowledged that while this testing effort was already underway, the state still lacked the testing supplies and staffing to make this happen within the desired timeframe. At that time, based at least in part on the shortage of supplies and staffing, there had been little testing of asymptomatic residents or staff.

On May 13th, CDPH issued AFL 20-53. In it, CDPH recommends SNFs include testing strategies informed by the CDC recommendations in their COVID-19 mitigation plans (announced in AFL 20-52). This plan should be developed in conjunction with CDPH and their local health department (LHD) that includes:

- Baseline testing for all SNF residents and HCP for any facility that does not currently have a positive case.
- 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.
- 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.
- Testing of symptomatic or exposed residents.
- An arrangement with laboratories to process tests. The test used should be able to detect SARS-CoV-2 virus (e.g., polymerase chain reaction (PCR)) with greater than 95 percent sensitivity, greater than 90 percent 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.

- A procedure for addressing residents or staff that decline or are unable to be tested (e.g., symptomatic resident refusing testing in a facility with positive (COVID-19 cases should be treated as positive).
- Plans for use and follow-up of test results including:
    - How results will be explained to the resident or HCP
    - How to communicate information about any positive cases of residents or HCP in the facility to family members or responsible parties
    - 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
    - How results will be used to guide implementation of infection control measures, resident placement, and HCP and resident cohorting
    - How results will be communicated to ensure appropriate management when residents are transferred to other congregate settings
    - 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
    - Plans to address potential staffing shortages if positive HCP are excluded from work

AFL 20-53 calls for both baseline testing and surveillance testing. In facilities without any positive COVID-19 cases: implement surveillance testing of 25 percent of all HCP every 7 days including staff from multiple shifts and facility locations. The testing plan should ensure that 100 percent of facility staff are tested each month. NOTE: State and local leaders may adjust the frequency of HCP testing based on community spread data and prevalence of the virus in the community.

After Los Angeles County SNFs did testing on asymptomatic residents, *LAist* reported that in Los Angeles County health officials tested more than 3,600 people, which resulted in 402 positive cases. But only 57 of the people who tested positive had symptoms. *LAist* further reported that 86% of the people (in the particular group tested) who tested positive were asymptomatic and quoted Barbara Ferrer, LA County's Public Health Director as saying, "These results highlight the fact that there may be, in any setting, significant numbers of people who are positive for COVID-19, with no symptoms. And this is particularly problematic in our institutional settings. Infection control-appropriate personal protective equipment and routine testing are essential for us to create safer environments for employees — and for residents."

Isolation of patients with COVID-19

In general, the recommended duration of the isolation period with transmission-based precautions (TBP) for individuals who have tested positive for COVID-19 follows the "14/7 rule": individuals should be isolated (either in a private room or cohorted with other COVID-19 patients) and use TBP for at least 14 days since the date of the positive test result AND, if ever symptomatic, at least 7 days since resolution of fever and substantial improvement in respiratory and other symptoms. Repeat testing of positive individuals is not needed, and if an individual

does happen to be tested again and tests positive again, a second isolation period is not needed. HCP who test positive should also follow the 14/7 rule to determine when they can return to work.

One issue raised by nursing home reform advocates is that, as county health departments look for locations where COVID-19 positive patients (who don't need hospitalization or those who are being released from the hospital) can be isolated from other patients, SNFs with poor quality ratings may not be the safest location to care for them. Concerns have been raised about nursing homes with poor quality ratings actively seeking to admit COVID-19 residents in order to maximize income. According to the *Los Angeles Times,* a new Medicare reimbursement system that went into effect last fall pays nursing homes substantially more for new patients (including those released from a hospital). Under those guidelines, reimbursement rates for COVID-19 patients can be as high $800 per day initially, according to nursing home administrators and medical directors interviewed by the *Los Angeles Times*. Reimbursement rates for longer-term patients varies based on the care needed, but can be as low as $200 per day.

Staffing Levels

While there have been staffing shortages at SNFs since the outbreak of COVID-19, staffing shortages pre-date the pandemic. In 2018, more than half of SNFs in California requested waivers from CDPH of the staffing requirement that residents receive 3.5 hours of direct care daily.

On March 30th Governor Newsom issued an Executive Order authorizing the CDPH Director to temporarily waive licensing and staffing requirements for hospitals and other health facilities. That same day, CDPH issued an ALF entitled "Suspension of Regulatory Enforcement of Specified Skilled Nursing Facility Requirements", which among other things suspended minimum staffing hours per patient.

For at least a time after the COVID-19 outbreak, the state was paying a stipend of $500 to 50,000 certified nurse assistants, licensed vocational nurses and other critical staff at SNFs to help ensure adequate staffing.

A recent analysis by academics from the University of California, San Francisco used data from CDPH, the Los Angeles Department of Public Health and news organizations to look at nursing homes reporting COVID-19 infections. According to this analysis, between March and May 4, 2020, nursing homes with total Registered Nurse (RN) staffing levels under the recommended minimum standard (.75 hours per resident day) had a two times greater probability of having COVID-19 resident infections.

Personal Protective Equipment (PPE)

Personal protective equipment, commonly referred to as "PPE", is equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses. In the case of the COVID-19 pandemic, PPE often includes items such as gloves, N-95 or surgical masks, face shields, respirators, and full body suits. Health care workers who care for nursing home residents have direct and frequent contact with residents, so an adequate supply and consistent use of PPE

is critical in preventing the spread of infection. Also, it is not uncommon for staff to work at more than one SNF, which can play a role in the spread of infection, particularly without adequate PPE.

Media reports detail the lack of PPE in some nursing home, especially early in the pandemic and health care workers resorting to using swimming googles, rain ponchos and other protective equipment that they obtained or made themselves when they could not obtain the PPE they needed from their employer.

The California Association of Health Facilities (CAHF) acknowledges that SNFs "have been affected by a severe shortage of personal protective equipment" and "are working with counties and the state to secure more PPE, but this has been an ongoing challenge. In some instances, staff are resorting to home-made source protection." Some of the PPE necessary for protection during this pandemic are not commonly used by most staff in the SNF, such as N-95 masks. The ability to acquire the quantity of needed PPE and the increased cost of this PPE are impacting SNFs. When a SNF is not able to acquire sufficient PPE on its own, they can seek PPE through the County Medical and Health Operational Area Coordination (MHOAC) system.

A WHO-funded analysis of 172 studies released this month confirms that N-95 and other respirator masks are far superior to surgical or cloth masks in protecting health care workers from COVID-19. N-95 masks offered 96 percent protection, the analysis found, while the figure for surgical masks was 67 percent. The analysis also suggests that covering the eyes with face shields, goggles or glasses may provide additional safeguards for health care workers. The CDC initially recommended N-95 masks for all health care personnel. The agency later downgraded its recommendations when faced with of a shortage of N-95 masks and other PPE.

CDPH's AFL 20-52 issued on May 11th states: "To account for the role of asymptomatic and pre-symptomatic transmission, CDC's infection control guidance recommends source control for everyone entering a healthcare facility (including, healthcare personnel (HCP), patients, and limited visitors), regardless of symptoms. 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 instead of a respirator or facemask during the provision of patient care.

Infection Control, pre-COVID-19

Prior to the COVID-19 outbreak, SNFs were required to have a trained Infection Preventionist (IP) on staff who ensures that written infection prevention policies and procedures are adhered to by HCP. The staff person serving as the IP generally had other responsibilities and did not devote all their time to infection prevention. The requirement was recently modified by CDPH's AFL 20-52 to require that one or more staff play this role full-time.

According to a March 13th, 2020 *Kaiser Family Foundation* report, deficiencies related to the spread of infectious disease are relatively common in nursing facilities, with nearly 40% of facilities having at least one infection control deficiency in 2017. Deficiencies related to infection control are the most common deficiency that nursing facilities report, followed by food

sanitation (36%) and accident environment (34%). In Delaware, Mississippi, Missouri, Illinois, Michigan, and California, over half of facilities reported at least one deficiency related to infection control. Infection control can be particularly challenging in SNFs where it is common for multiple residents to share one room.

On April 17th, *the Washington Post* reported that forty percent of more than 650 nursing homes nationwide with publicly reported cases of COVID-19 (at that time) had previously been cited more than once in recent years for violating federal standards meant to control the spread of infections. Dozens of those SNFs with multiple previous violations were in California. That data has been updated and of the more than 1300 SNFs with COVID-19 cases, 45% of them had been cited in recent years for multiple infection control lapses. In California, there were close to 200 SNFs with COVID-19 cases that had previously been cited for multiple infection control lapses.

The pandemic has brought renewed attention to widespread and longstanding problems in the nursing home industry, particularly related to infection prevention and staffing levels. At the same time, the nursing home industry is lobbying to secure immunity from lawsuits that may be filed by residents or their family members about practices and conditions in their facilities.

Federal Actions and Support

On March 13th, the CDC issued guidelines for SNFs restricting all visitation except for end of life situations; Restricting all volunteers and non-essential healthcare personnel (HCP), including non-essential healthcare personnel (e.g., barbers); Canceling all group activities and communal dining; and Implementing active screening of residents and HCP for fever and respiratory symptoms.

On May 8th, CMS published an interim final rule requiring SNFs to report facility data about COVID-19 cases and deaths, staffing shortages, PPE and medical supplies to CMS via the state (CDPH) on a daily basis. Residents and their representatives must be notified when there are COVID-19 positive residents or staff.

The Government Accounting Office GAO issued a report on May 20th in which it examined CMS's oversight of infection prevention and control protocols and the adequacy of emergency preparedness standards for emerging infectious diseases in nursing homes. The report notes that in 2017, 61% of surveyed nursing homes in California were cited with an infection prevention and control deficiency, far above the state average of 39.6%. Additionally, 63% of SNFs surveyed in California from 2013-2017 had infection prevention and control deficiencies cited in multiple consecutive years. The GAO report notes that, "Infection prevention and control deficiencies cited by surveyors can include situations where nursing home staff did not regularly use proper hand hygiene or failed to implement preventive measures during an infectious disease outbreak, such as isolating sick residents and using masks and other personal protective equipment to control the spread of infection. Many of these practices can be critical to preventing the spread of infectious diseases, including COVID19."

On May 22nd, the Department of Health and Human Services (HHS) announced the availability of $4.9 billion in additional relief funds to SNFs. The funding is provided through Provider

Relief Fund which was appropriated in the CARES Act and the Paycheck Protection Program and Health Care Enhancement Act. Each certified SNF with six or more beds should receive $50,000, plus $2,500 per bed. HHS notes that the additional funds should help SNFs address critical needs such as labor, scaling up testing capacity, acquiring PPE, and other expenses related to the pandemic.

On June 1, CMS announced enhanced enforcement for nursing homes with violations of longstanding infection control practices. The CARES Act provided funding to CMS for survey and certification work related to COVID-19. Of this funding, $80 million will be available for states to increase surveillance and certification activities, and CMS will allocate the funding using performance-based metrics. States that have not completed 100 percent of focused infection control surveys of their nursing homes by July 31, 2020, will be required to submit a corrective action plan to their CMS location outlining the strategy for completion of the surveys within 30 days. If states have not performed 100 percent of their surveys after the 30-day extension, their CARES Act 2021 allocation may be reduced by 10 percent. According to CMS data, California had completed surveys of 94.7% of its SNF as of June 1, 2020.

Racial Disparities

On May 22nd, the *New York Times* reported that nationally SNFs with a significant number of Black and Latino residents are far more likely to have COVID-19 outbreaks than those where the population is predominately white. "Nursing homes where those groups make up a significant portion of the residents — no matter their location, no matter their size, no matter their government rating — have been twice as likely to get hit by the coronavirus as those where the population is overwhelmingly white." According to this reporting, in California, 47% of SNFs at which at least 25% of the residents are Black and Latino have at least one case of COVID-19 versus only 18% of facilities at which less than 5% of the residents are Black or Latino. The *New York Times* further reports that the facilities that serve predominantly Black and Latino residents tend to receive fewer stars on government quality ratings. Those facilities also tend to house more residents and to be located in urban areas, which are risk factors during a pandemic.

CDPH's daily reporting of COVID-19 cases and deaths statewide shows that for adults 18 and older, Latinos, African Americans and Native Hawaiians and Pacific Islanders are dying at disproportionately higher levels than others. The proportion of COVID-19 deaths in African Americans is about double their population representation in California across all adult age categories.

Areas for Further Consideration or Action Going Forward:

COVID-19 has had a disproportionate impact on those over age 65, residents and staff at SNFs and people of color. The Legislature, the state auditor and advocates had identified issues of concern at SNFs long before this pandemic, but the incidence of COVID-19 and the death toll associated with SNFs that are charged with caring for vulnerable populations necessitates renewed attention.

Testing: Is testing being done for all residents and staff at the levels now required by CMS and CDPH? Are rapid testing results available for all facilities? If not, are the supplies available, is there adequate staffing to perform tests, are there additional ongoing barriers?

Staffing Levels: Does waiving state requirements for staffing levels for providing direct care to patients put residents at greater risk? If there are ongoing staffing shortages at some facilities, what is being done to increase staffing? Should facilities that are understaffed continue to admit new residents?

PPE: Do California's SNFs have the PPE needed to properly care for residents and protect staff at each facility? How can we ensure there is enough PPE if have resurgence?

Transparency and Oversight – What data does the public need in order to know that their loved ones are safe? Do policymakers need data that would allow them to better track whether there is a connection between facilities that have previously been cited for violating the law and those with a high incidence of COVID-19? Are facilities with higher rates of residents with Medi-Cal coverage seeing higher incidence of COVID-19?

Restrictions for visiting loved ones in SNFs have been in place since mid-March. Some residents have never before in their lives gone this long without seeing family members and this can directly impact their health. Under what circumstances would it be safe to alter any of the existing restrictions in order to allow some family and friends (who often act as caregivers and advocates for their loved ones in SNFs) to have some ability to visit?