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IMPACT OF COVID-19 ON LONG-TERM CARE IN CALIFORNIA

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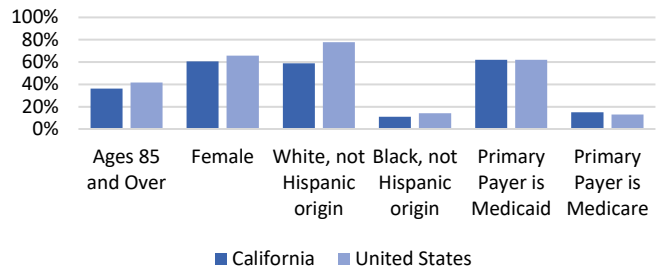
STATE LONG-TERM CARE SETTING

GENERAL (PRE-COVID) SETTING AND CONTEXT

California is the most populous state in the US, with 39.5 million residents (1). It has a slightly younger age distribution relative to the national average, with 13.3% and 1.8% of its population respectively aged over 65 and 85 in 2015, compared to national averages of 14.9% and 2.0% (2). Among its population aged 65-plus, Californians report higher rates of difficulties with self-care (10.1% versus 8.1%) and cognitive difficulties (10.3% versus 8.9%) compared to the national average.

Figure 1. Characteristics of California Nursing Facility Residents



There are approximately 120,000 residents living in 1,224 skilled nursing facilities (SNFs) in California (3). As outlined in Figure 1, California's SNF residents tend to be younger than the national average (36% are over age 85 compared to 42% nationally). Most residents are female (61% versus 66% nationally). A much smaller proportion than the national average is non-Hispanic white (59% versus 78% nationally) and a slightly lower proportion is non-Hispanic Black (11% versus 14% nationally). California's SNFs are licensed by the California Department of Public Health (CDPH), which conducts on-site inspections of SNFs and responds to complaints and reportable events related to the facilities. 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 (3). The state auditor has conducted multiple audits related to the quality of care at California's Skilled Nursing Facilities in recent years due to concerns about ongoing deficiencies related to quality of care. From 2006 through 2015, the number of substandard care deficiencies that nursing facilities received increased by 31% (3). In 2009, the Centers for Medicare and Medicaid Services (CMS) found that 42% of California's nursing homes rated "below average" or "much below average" with respect to health inspections (4).

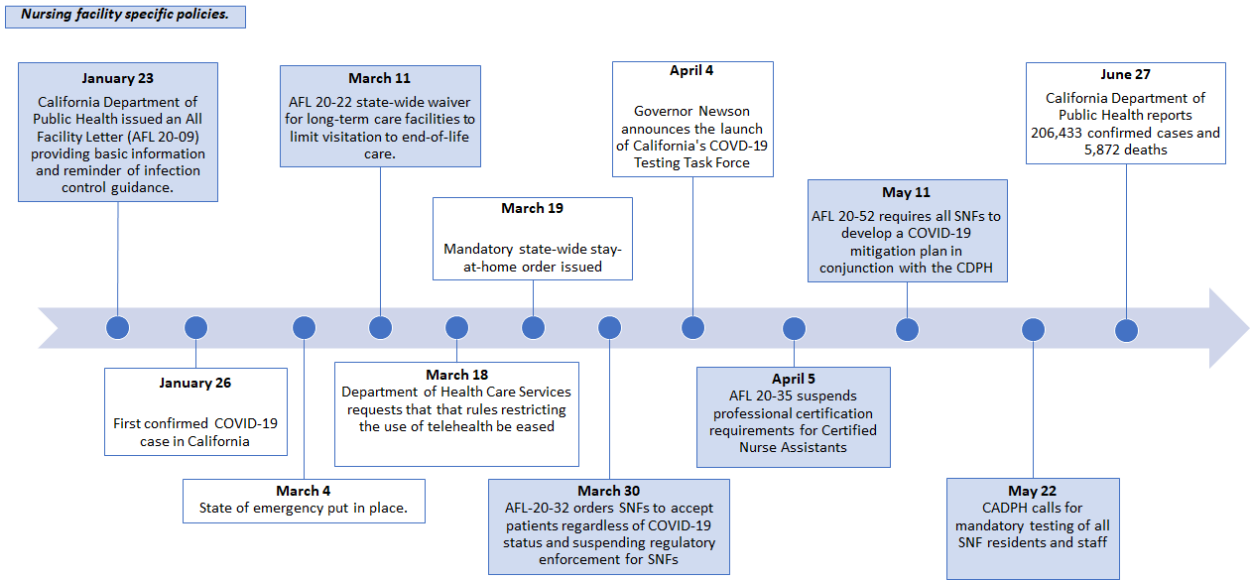
As of 2016, 83.5% of California's skilled nursing facilities were for-profit, while 12.6% operated as non-profits and 3% were government run (5). Medicaid is the primary payer for nursing facility service in California, covering the costs for 62% of nursing home residents, which is the national average. A slightly higher proportion of SNF residents are covered by Medicare relative to the national average (15% versus 13%). California ranks 44th in the country with respect to institutional services spending per capita, with an average of $142 spent per person (2). In 2016, 19% of California's $83.9 billion Medicaid spending was dedicated to fee-for-service long-term services and support (LTSS), with approximately 35% of this spending dedicated to nursing facilities (2). The state Medicaid program (Medi-Cal) offers home- and community-based waivers for in-home care, and California ranks 26th in the country with respect to per capita Medicaid spending on HCBS, spending $256 per person. The median wage for nursing assistants was $14.84 per hour in 2017 (12th in the country), and the state includes some of the highest cost areas in the US. These higher costs are reflected in above average costs for private pay nursing facilities ($116,435 versus a national average of $97,455). The uptake of private long-term care insurance is around 46 per 1000 people over aged 40, with is around average the US (2).

STATE COVID-19 OUTBREAK AND POPULATION LEVEL MEASURES

STATE COVID-19 CONTEXT

California's first case of COVID-19 was confirmed on January 26, 2020 (see Figure 2). As of July 4, 2020, the CDPH reported 260,155 confirmed cases of COVID-19 (644 per 100,000) and 6,331 COVID-19 related fatalities (6). As of July 3, 2020, 14,074 (2,541) SNF residents and 9, 156 (93) SNF health care workers have tested positive (died) in California (7). Based on these figures, at least 42% of those who have died from COVID-19 in California were residents or health care workers at SNFs. According to a media analysis of Centers for Disease Control Data, 73 of the state's 1,224 nursing homes had had more than 10 deaths due to COVID-19, as of June 11. Taken together, those 73 SNFs accounted for more than 55% of the state's total nursing home deaths. This proportion was slightly higher in LA County, with 50% of those who have died from COVID-19 being SNF residents or employees as of the end of the study period, end of June 2020 (8).

Figure 2. Initial Response to COVID-19 in California



RISK MITIGATION STRATEGIES

Testing

Testing task force and goals. On April 4th, Governor Newson announced the launch of California's COVID-19 Testing Task Force. The mission of the group was to coordinate public and private sector efforts to increase access to testing across California, addressing issues such as lab capacity and turnaround times, the development of new, high quality tests, accuracy of tracking testing capacity and results, and building the necessary workforce to meet testing needs. In addition to prioritizing residents and staff of congregate living facilities, hospitalized patients, and healthcare workers, the task force prioritized testing of both symptomatic and asymptomatic persons aged 65-plus (3).

Following May 12th federal recommendations that all states test nursing home residents and staff, the CDPH issued an All Facility Letter (AFL 20-53) on May 13th, which recommended that SNFs include testing strategies informed by CDC recommendations in their COVID-19 mitigation plans. AFL 20-53 called for both baseline testing and surveillance testing. In facilities without any positive COVID-19 cases, it was recommended that surveillance testing of 25% of all health care workers every 7 days occur. The testing plans were supposed to ensure that 100% of facility staff were tested each month and were

expected to meet the following criteria: 1) baseline testing for all SNF residents and workers for any facility that did not have a positive case; 2) testing residents prior to admission or readmission, including transfers, and quarantining in the absence of a test; 3) testing of residents admitted from the hospital, quarantining for 14 days, and retesting if they tested negative; 4) testing of symptomatic or exposed residents; 5) arrangements with laboratories to process tests, with results obtained rapidly (e.g., within 48 hours); and 6) a procedure for addressing residents or staff that decline or were unable to be tested.

Testing goals have been hard to achieve. While all SNFs were supposed to have baseline testing of all residents and workers following AFL 20-53, as of June 17, only 21% of California's nursing homes (256 sites) had submitted the results of baseline testing for their residents and workers, according to the CDPH (9). Meanwhile, the California Department of Social Services, which regulates assisted living facilities, board and care facilities, and other care homes did not issue similar recommendations as CDPH did for SNFs (10).

Financing and ensuring supply of tests has been difficult for some counties. Generally, counties have assumed that testing kits, which are estimated to cost at least $100 per test, can be billed to private insurance. However, there are concerns among SNF representatives that the repeat testing requirements will not be covered. Further, it has been left to local and county entities to decide how they will support facilities in conducting these tests. Some counties have entered into private partnerships to received tests (e.g. Santa Clara County has received tests from the Chan Zuckerberg Biohub laboratory), while others are relying heavily on federal funds (e.g. San Mateo County is expecting 50%-75% of the costs of testing all congregate living facilities to be covered by the Federal Emergency Management Agency) (11).

Testing turnaround has improved over time. As was the case with other states, in the months following the onset of COVID-19, there were significant delays with labs processing tests. The media reported that people had to wait up to 10 days to learn the results of their tests, and in early April there was a backlog of 60,000 unprocessed tests (i.e. 64% of the total administered tests at the time) (12). At the end of April, however, California's backlog of tests was cleared, and most people learn their results within days (13).

Facility direct care changes

Relaxing regulatory enforcement and minimum staffing requirements. On March 30, the CDPH issued an executive order entitled "Suspension of Regulatory Enforcement of Specified Skilled Nursing Facility Requirements" (N-39-20), which among other things suspended minimum staffing hours per patient (3). This waiver is under the condition that facilities will notify the CDPH of any staffing shortages that jeopardize patient care. While the intent of this order was to ease the regulatory burden faced by SNFs, it has brought renewed attention to California's previously poor track record with respect to infection control. In 2017, 61% of surveyed nursing homes in California were cited with an infection prevention and control deficiency, far above the state facility 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 (3). A recent analysis by Harrington et al. has further highlighted the potential drawbacks of rescinding penalties for SNFs that do not meet regulatory requirements. Using data from the CDPH, the Los Angeles Department of Public Health (LADPH), and news organizations, the authors found that between March and May 4, 2020, nursing homes with total Registered Nurse (RN) staffing levels under the recommended minimum standard (0.75 hours per resident day) were two times more likely to have COVID-19 resident infections (3).

Telehealth expansion. To compensate for the decline in health care workers at SNFs and to limit growth in the use of these services, the Department of Health Care Services (DHCS) requested that that rules restricting the use of telehealth (Section 35 of the Social Security Act) be eased (14). Specifically, 1) care provided by home health agencies and care coordination agencies could be delivered via telehealth, as deemed appropriate; 2) could be delivered through non-HIPAA compliant devices; and 3) could be provided by Medicare or Medicaid providers enrolled outside the state. These changes were requested on March 18th and were made retroactive to January 27, 2020 (15).

General infection control guidance was provided early and frequently. Early actions related to infection control were taken by the CDPH a few days before the first confirmed case of COVID-19 in California. On January 23, an All Facility Letter (AFL 20-09) was sent out to healthcare facilities (including SNFs) providing reminders about infection control guidance and basic procedures for symptomatic patients (3). AFLs have been released regularly by the CDPH since January. Since March, the CDPH has collaborated with the California Association of Long Term Care Medicine and Health Services Advisory Group to host weekly webinars about infection prevention for long-term care facilities.

Establishment of enforceable standards for infection control was delayed. Enforceable infection control standards were not developed until May 11, 2020. AFL 20-52 required all SNFs to develop a plan in conjunction with the CDPH and their local health department to expand their existing infection control policies so that they included the development and implementation of a CDPH-approved COVID-19 mitigation plan. The mitigation plan had to include six elements: 1) regular testing of residents and staff, as well as cohorting; 2) the designation of a full-time Infection Preventionist; 3) a plan for adequate provision of PPE; 4) policies to address staffing shortages and crisis capacity strategies; 5) the designation of spaces to ensure separation of infected patients and eliminating movement of health care workers among those spaces; and 6) a designated staff member assigned to daily communications with staff, residents, and their families. These mitigation plans were supposed to be submitted by each SNF to the CDPH by June 1, 2020, and each facility is supposed to receive a visit from the CDPH to validate its certification at least every six to eight weeks (3).

SNF acceptance of COVID-19 patients and the designation of COVID-19 positive SNFs. Amidst the above noted actions taken to protect SNFs from a COVID-19 outbreak, the CDPH created significant confusion in March when it sent out an All Facility Letter to California SNFs instructing them to "prepare for residents with suspected of confirmed COVID-19 infection" (16). In addition to easing regulatory burden for SNFs, the March 30th directive also ordered SNFs to accept patients regardless of COVID-19 status. This directive was put in place in the context of hospital systems that were trying to prepare for rapid growth in the number of COVID-19 patients by discharging as many patients as possible, including nursing home residents (17). Both the CDPH and the LACDPH sent out follow up communications indicating that, instead, some SNFs in the state would be designated as "COVID-19 positive" facilities, on the condition that the facility had a department approved plan for keeping patients in these facilities safe. In some cases, such as in San Mateo County, designated SNFs were identified based on previous high standards of patient care and expertise in infection control (18). However, there are also examples from other counties of SNFs with low quality ratings prior to COVID-19 being designated as COVID-19 positive facilities and, subsequently, witnessing significant outbreaks (19). Some counties opted to designate non-SNF sites to care for post-hospital discharge COVID-19 positive SNF patients, such as the County of San Luis Obispo which opened an Alternate Care Site at a recreation center (20).

LTC facility worker policy changes

Efforts to increase counteract staffing shortages. There are currently staffing shortages at SNFs, but a number of sources have noted that these shortages pre-date the outbreak of COVID-19 (3). Since the pandemic started, some efforts have been made to try to increase staff-patient ratios in SNFs. On April 5, the CDPH released an All Facility Letter (AFL 20-35) suspending professional certification requirements for Certified Nurse Assistants (CNAs) (21). Several counties also took additional steps, reaching out to community members and other organizations. For instance, the County of Santa Clara Emergency Operations Center distributed a survey for residents to document skills and match them with specific nursing home needs, such as janitorial services and social work (22). Meanwhile the Los Angeles County Emergency Operations Center engaged the National Guard to provide ancillary support in SNFs with COVID-19 (23). The State of California also partnered with United Airlines in April 2020 to provide free, round-trip flights for volunteer medical professionals from across California and the country who joined the state's health care workforce (24).

In an effort to address financial burden faced by overworked SNF workers, the Office of Statewide Health Planning and Development (OSHPD) announced the launch of the Skilled Nursing Facility Hero Awards on April 14, 2020. The award was a one-time $500 stipend for licensed vocational nurses (LVNs) and CNAs working in a SNF. The stipends, which were to be provided to the first 50,000 qualified applicants, were funded through a $25 million financial donation from Facebook (25).

Significant lack of personal protective equipment. There has been extensive reporting on the lack of personal protective equipment (PPE) in the media. The California Association of Health Facilities has issued a statement outlining the ongoing challenges of securing sufficient PPE, noting that staff in some instances have resorted to home-made source protections (3). When a SNF is unable to acquire sufficient PPE on its own, they can seek PPE through the County Medical and Health Operational Area Coordination system. A CDPH All Facility Letter (AFL 20-52), released on May 11th, notes that cloth face coverings are not sufficient for health care workers and that evidence suggests N-95 are far superior to cloth masks and surgical masks with respect to the level of protection offered. As such, the State of California partnered with Battelle Memorial Institute, a private nonprofit applied science and technology development company headquartered in Ohio, to deploy their emergency-use authorized decontamination systems to safely reuse N-95 respirators (26).

Resident life changes

SNF visitation waivers. On March 11, 2020 the CDPH implemented its first directive aimed specifically at nursing homes in the form of a visitation waiver. CDPH authorized a statewide waiver (AFL 20-22) for long-term care facilities to modify their visitation policies in accordance with Centers for Medicaid and Medicare (CMS) guidelines. At this time, the CDC recommended limiting SNF visitors aside from essential personnel, with the exception of end-of-life visitation (27). On April 30th the California Department of Aging issued answers to commonly asked questions for friends and family of SNF or Residential Care Facility residents. This included suggestions both for how to connect with a resident via telecommunications, for getting information about what is happening at the facility, and for gathering information about cases of COVID-19 at a given facility. Information about what actions the state is taking to keep people in SNFs safe and how to file a complaint against a nursing home was also included (3).

Communal dining suspension in some counties. Some counties and cities opted to suspend communal dining and group activities in their SNFs. In early- to mid-April, counties across the San Francisco Bay

Area issued updated requirements that would be monitored for compliance by the entities' respective departments of public health. Los Angeles County followed suit on April 24, implemented similar restrictions around communal dining and group activities (28).

FINANCIAL SHOCKS AND STRATEGIES FOR RESILIENCE / REPORTING

Financing changes

Financial incentives for taking COVID-19 patients. The number of media sources have reported about financial incentives being offered to facilities to take in COVID-19 patients. Assisted living facilities across California were sent a letter from the Department of Social Services on May 1, notifying them that facilities with six or fewer residents would receive $1,000 per day (around $30,000 per month), for each COVID-19 patient that they took in (29). This is a significant increase over the median cost in the state, which is $4,500 per month. In Los Angeles County, there were similar financial incentives put in place for nursing homes, and early adopters of the policy to take in only COVID-19 positive patients charged $850 per day per patient (30).

Rescinding planned state budget cuts to HCBS. The planned May revision to the state budget was supposed to eliminate funding for Adult Day Health Care/Community Based Adult Services and Multi-Purpose Senior Services. Because this would likely increase demand for nursing home care, the budget agreement that was announced on June 3 rejected these cuts, despite the state facing a budget deficit of $54 billion in 2020-2021 (3,31).

Transparency

CDPH requires daily updates via an online survey. On May 13, 2020, the CDPH released an All Facility Letter (AFL 20-43) requiring SNFs to report daily updates regarding current staffing levels, the number of COVID19 patients, and equipment availability to the CDPH via an online survey. To meet the Centers for Disease Control and Prevention (CDC) reporting requirements, the CDPH modified their daily online survey to include the questions required by the CDC via the National Healthcare Safety Network (NHSN) (32). The CDPH reports this data to the CDC on behalf of facilities via the online SNF COVID-19 Survey.

Public data on testing remain inconsistent. Despite the above outlined plans for testing, media have reported significant inconsistencies and a lack of details related to daily testing counts and who is being tested. The CDPH testing statistics do not include where tests are being conducted or demographic information about who is being tested. Further, county-level testing data has been found to be inconsistent between jurisdictions (13).

CHANGES, NEEDS, AND CALLS FOR ACTION

Issues being addressed

Independent assessments of state and county responses to COVID-19. On May 26, the Los Angeles County Board of Supervisors voted unanimously to appoint an independent inspector general to look into the county's oversight of nursing homes, including the county health department's testing rates (33). This was the first time an Inspector General has been appointed to oversee SNFs in the county. The board tasked the Inspector General with developing recommendations on how to strengthen oversight of SNFs and how to improve their operations in the long-term.

Issues identified but not yet addressed

Legal immunity for SNFs and ALCs related to their COVID-19 response efforts. In April, facilities across the state, including SNFs, addressed a letter to Governor Newsom requesting protection from lawsuits and criminal prosecution for decisions made during the COVID-19 crisis. As of July, there has been no executive order from the Governor's office addressing this request. Media outlets have interpreted this inaction as the Governor's Office unwillingness to shield facilities from most lawsuits related to COVID-19 (34).

Worse outcomes for residents in SNFs with predominantly Black and Latino populations. 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, compared to only 18% of facilities at which less than 5% of the residents are Black or Latino. The *New York Times* has reported 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 (3).

OTHER

California's compliance with the CMS CARES Act. 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. States that have not completed 100% of focused infection control surveys of their SNFs by July 31, 2020, will be required to submit a corrective action plan to their CMS location within 30 days. If states have not performed 100% of their surveys after the 30-day extension, their CARES Act 2021 allocation may be reduced by 10%. According to CMS data, California had completed surveys of 94.7% of its SNFs as of June 1, 2020 (3).

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