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# IMPACT OF COVID-19 ON LONG-TERM CARE IN PENNSYLVANIA

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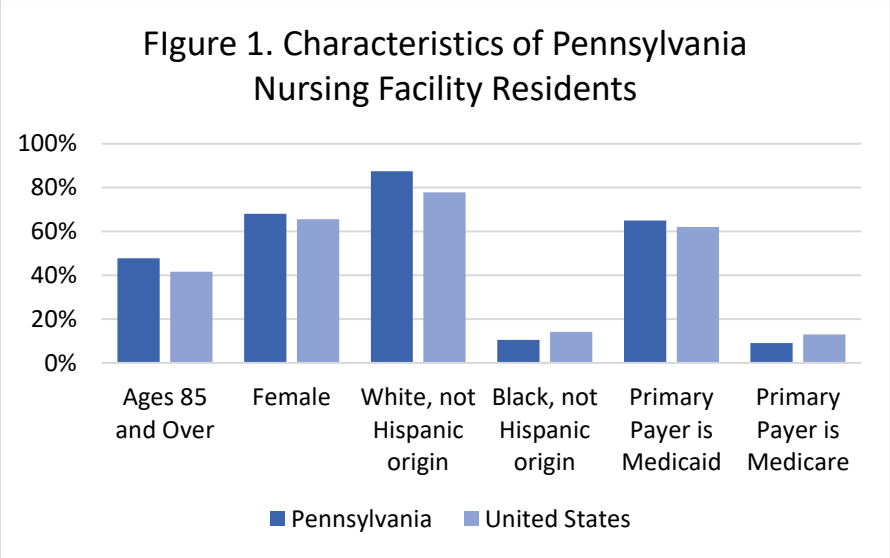
# STATE LONG-TERM CARE SETTING

## GENERAL (PRE-COVID) SETTING AND CONTEXT

Pennsylvania (PA) has 12.8 million residents and is a racially and ethnically diverse state with 10% Black, 8% Hispanic, 4% Asian and 76% white residents. Around 18% of residents are 65 years of age or older and 11% live in rural areas. Most residents were U.S. born, with 7.2% of Pennsylvanians born outside the United States.




Just over half of long-term care (LTC) facilities are for-profit (54%) and the remainder are non-profit (42%) or government owned (4%). The managed care penetration rate is 61%, and Medicaid reimbursement rates for physician fees is 93% the national average. The mean hourly wage for a Certified Nurse Assistant (CNA) in PA is $14.43, higher than the national average of $11.00. The most common unions are LeadingAge PA, SEIU Healthcare Pennsylvania, National Union of Hospital & Health Care Employees District 1199C, and UFCW 1776KS. Nursing homes are regulated by the Department of Health (DOH), and Assisted Living and Personal Care services are regulated by the Department of Human Services

Compared to the national averages, Pennsylvania nursing homes have higher proportions of residents who are 85 or older (~41%), female (~65%), and non-Hispanic white (82%) (Figure 1). Similar to most states, Medicaid is the primary payor for nursing home care, at around 62% being covered by Medicaid; however, Pennsylvania does not allow Medicaid to cover assisted living stays. Medicare covers around 8% of nursing facility residents through its post-acute care benefit.

# STATE COVID-19 OUTBREAK AND POPULATION LEVEL MEASURES

## STATE COVID-19 CONTEXT

In response to the COVID-19 outbreak in 2020, Pennsylvania officials ordered the closure of public schools March 16, banned visits to nursing homes March 17, and closed non-essential businesses March 19. Shelter-in-place orders occurred two weeks later, on April 1. In early May, Pennsylvania began to reopen businesses on a county-by-county basis, using a 3-level color-coded system to represent the status of the pandemic by county. Against advice and state orders, the Lebanon County commissioners voted 2 to 1 to prematurely reopen in late May. All counties were in some phase of reopening by June 5 (yellow or green), and most reopened all businesses (including restaurants, bars, and personal services) by June 26 (green), with capacity and group size restrictions. The state's Department of Health released

reopening plan for nursing homes on June 27, which continued visitor restrictions for 28 days after a county has moved to "green".

**COVID-19 in LTC.** By June 26, 2020, there were 88,950 cases of COVID-19 and 6,625 deaths in Pennsylvania, with a daily incidence down to about 720 cases and 23 deaths after peaking in April at 2000 cases and approximately 250 deaths, respectively. In the same period, there were 16,603 COVID-19 cases in LTC facilities (this combines staff and residents) and 3,090 deaths in LTC facilities. Strikingly, LTC facilities accounted for over 60% of the state's deaths (Freopp.org), but only 23% of the state's cases.

Figure 3A. Pennsylvania Cumulative COVID-19 Cases and Deaths

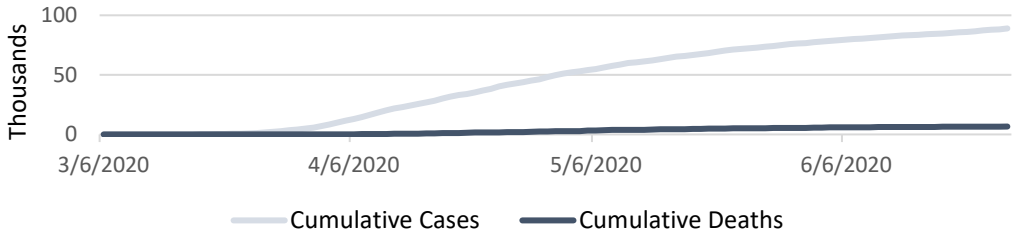
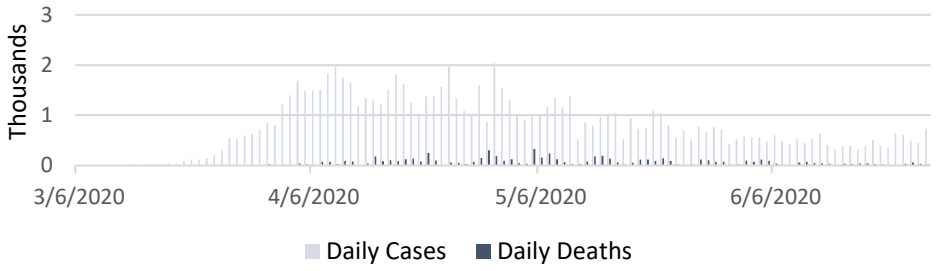



Figure 3B. Pennsylvania Daily COVID-19 Cases and Death




COVID-19 response efforts have devastated Pennsylvania LTC facilities. While daily cases peaked in April, state legislation to provide funding assistance was not signed until May 29th. While waiting on this assurance, existing financial strain in the LTC facility industry and staffing shortages were exacerbated by the rapid spread of the epidemic and delayed response.

## RISK MITIGATION STRATEGIES

**Universal routine testing**: Universal testing guidance in LTC facilities was issued in May by the DOH, but it was not required by an order. In facilities without active COVID-19 transmission, the DOH urged facilities to implement an aggressive strategy to test staff or residents with COVID-19 compatible symptoms. However, routine testing of asymptomatic staff or residents was not required at that time. Rather, facilities were asked to make their own decisions regarding testing and isolation of asymptomatic healthcare workers based on a) local epidemiology, b) staffing needs c) consistent with crisis standards of care and emergency preparedness planning. LTC facilities were urged to follow

guidance regarding work quarantine and isolation of staff and residents after health care-associated exposures.

While the state recommended weekly testing or all residents and staff starting June 1, limited supply of testing kits and delays in testing turnaround hampered this effort. Subsequently, the state mandated that all nursing home staff and residents be tested by July 24, supplied nursing homes with testing kits, and contracted with labs for test results.

**Supply and Distribution of PPE:** As part of aggressive source control measures, healthcare facilities were required to implement face mask policies for everyone entering the facility regardless of symptoms. This approach was consistent with recommendations to the general public. Pennsylvania also provided guidance that providers should have received job-specific training on PPE and demonstrated competency with selection and proper use (e.g., putting on and removing without self-contamination).

Per Executive Order, LTC facilities were required to report inventories of specified supplies, equipment, and pharmaceuticals including durable medical equipment (such as ventilators and ECMO machines). The inventory tool was intended to ensure the efficient allocation and effective use of critical medical resources, such as N95 face masks, ventilators, respirators, face shields, and certain pharmaceuticals by hospitals and healthcare facilities in the state.

Federal Emergency Management Agency (FEMA) provided PPE to the state, and the state distributed the PPE. At the beginning of the emergency response, Pennsylvania Emergency Management Agency (PEMA) reviewed resource requests, in consultation with DOH, and distributed resources in response to those requests. As of late June, 2020, PPE was being provided directly from DOH and PEMA to healthcare facilities with the greatest need. Other avenues of supplying equipment and supplies included the normal supply chain, state or federal stockpiles of equipment, and using alternate sources.

## Facility direct care changes

**Delivery of care changed to mitigate COVID-19 spread.** On March 18, the Pennsylvania DOH directed LTC facilities to continue admitting new COVID-positive patients and to readmit current residents after hospital stays, including potentially stable patients who have had the COVID-19 virus. The goal of this directive was maintaining capacity in Pennsylvania's acute care hospitals. Patients with COVID-19 should be admitted to a facility that was able to adhere to infection prevention and control recommendations for the care of COVID-19 patients, and preferably be placed in a location designated to care for COVID-19 residents. Although the state has regulatory power, the city of Philadelphia issued contrary recommendations, allowing facilities to refuse admission to new or returning residents until criteria demonstrating COVID-19 negative status were met.

**Cohorting residents:** Pennsylvania allowed facilities that met the standards of a planning strategy to submit a request for approval to expand the number of beds or convert closed wings or entire facilities to support COVID-19 patients or residents (PA-HAN 496). Approval was based on whether beds were Medicare or Medicaid certified, available equipment, and many other domains including whether residents with COVID-19 would be handled (e.g., moving within the facility, admitted from other facilities, admitted from the hospital), and whether and how any existing residents would be displaced (especially dementia patients). The directive also recommended that staff be 'cohorted',

that is, if they have been working with COVID-19 patients they should continue to, following all PPE guidelines. The order also proposed that staff bundle tasks and perform roles that have typically been outside their usual tasks, such as one person delivering food tray and checking vital signs, to optimize PPE use and limit staff's exposure to COVID-19.

### *Staffing*

**Regulatory changes were made to alleviate staffing shortages.** A CMS waiver declared on March 13, 2020 that a nursing care facility could employ staff up to four months without meeting training and certification requirements, with the exception of requirements for nurse aides. Facilities were still held responsible for ensuring direct providers meet competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments and described in the plan of care. Additionally, the Governor and Department of State lifted other guidelines to make it easier to work to meet the needs of the pandemic, such as providing temporary permits for nurses licensed in other states, and reactivating retired RNs, CRNPs and clinical nurse specialists. Finally, the state extended renewal deadlines for nursing professional licenses.

**Communal activities and visitors for residents were restricted until their Region was designated as Green**. Communal meals were replaced with in-room meal service for residents capable of feeding themselves. Residents who need assistance with feeding were permitted to eat in a common area as long as they were spaced apart, ideally six feet or more, or at individual tables. Staggered start times and reduced groups sizes were common strategies for accommodating these changes. Staff members who are assisting more than one resident at the same time must perform hand hygiene with at least hand sanitizer each time when switching assistance between residents. Additional precautions included physical barriers, sanitizer and supplies, and visual alerts to ensure everyone adheres to hand hygiene and other preventive etiquette.

Per the Governor's guidance (HAP 492), nursing care facilities were told to limit outside visitors to the greatest extent possible to limit exposure for residents. Visitation policies permitted essential health care workers, social service providers (The Department of Aging/Area Agency on Aging and the Department of Human Services), and end-of-life visits (hospice services, clergy, and bereavement counselors). Visits from non-essential ancillary therapeutic services (physical therapy) were restricted. There are also instructions to minimize resident interactions with other personnel and contractors performing essential services (e.g., plumbers, electricians, etc.) through actions such as using separate entrances, performing service at off-hours, and performing only essential servicing activities. Furthermore, facilities were urged to arrange for deliveries to areas where there is limited person-to-person interaction.

## FINANCIAL SHOCKS AND STRATEGIES FOR RESILIENCE / REPORTING

**Financial changes.** Facilities faced a 400% surge in expenses associated with increased costs for critical supplies and payrolls according to PCHA. While these expenses were partially covered through federal stimulus funds, tracking the use of stimulus funds was a burden. Equipment prices rose with demand. PA Senior Protection Act to Safeguard At-Risk Seniors allocated $245 million from Pennsylvania's federal COVID-19 funds to nursing homes and $50 million to assisted living and personal care homes. In addition to increased expenses, facilities also experienced reduced revenues. The suspension of elective surgeries during the COVID-19 epidemic meant fewer short term residents needing care following hospitalization.

### *Transparency and Reporting*

On April 21, 2020, the Pennsylvania's Secretary of Health issued an order requiring all licensed Pennsylvania nursing care facilities to complete the Nursing Care Facility Survey in the Knowledge Center daily, reporting both 1) total number of cases for residents and staff and 2) new cases in the last week. Some questions have been raised about the reliability of this data and a disclaimer has been posted to the DOH website alerting viewers to the inaccuracies.

## CHANGES, NEEDS, AND CALLS FOR ACTION

**Implementing Point of Care Testing:** By the end of July, all 693 licensed nursing homes met the state's deadline to complete initial COVID-19 testing of residents and staff. To make this possible, the DOH partnered with CVS Health and a Lancaster-based lab, Eurofins, to administer up to 50,000 tests for nursing home residents and staff. Although this testing milestone of one-time testing was met, routine testing will require a more reliable testing supply and processes. Point-of-care testing within the facility is one promising solution to alleviate delays in results and reduce the burden on local laboratories, however the lower accuracy of point-of-care may limit its utility. Additionally, as of the end of July, the Pennsylvania Health Care Association reported that only a few member facilities had received point-of-care rapid testing devices from CMS. In addition to the devices, facilities will need training and a consistent supply to administer the tests reliably.

**New collaborations meet evolving needs.** Despite efforts of the DOH, some nursing homes continued to report they lacked necessary PPE and that some of what has been distributed was unusable. Public-private collaborations have filled in some of the gaps in the supply chain; for example, the Pennsylvania Health Care Association partnered with Harrisburg University to produce 250 3D face shields for long-term care workers. In June, the state formed a partnership with General Healthcare Resources to deploy onsite assessment teams to support COVID-19 response. In July, the Regional Response Health Collaboration Program was launched as a collaboration between the DHS and nine Pennsylvania academic health systems to support local regulatory agencies and LTC facilities in developing COVID-19 readiness and response planning. Regional call centers are available 24/7 to provide operational and administrative support to nursing homes, personal care and assisted living providers.

**Sustainable funding solutions are needed:** The current crises has led to budget deficits following flat Medicaid funding for seven years in a row. Without additional support, financial strain may trigger closures or changes in ownership for some facilities. Pennsylvania allocated $245 million of CARES funding to support nursing facilities, and an additional $50 million toward hazard pay bonuses for essential workers, including residential care facilities staff. Emergency funding was necessary; however, COVID-19 will be a concern for the foreseeable future, and long-term solutions to LTC funding are needed to develop a sustainable, more equitable system for aging services and supports.