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

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STATE LONG-TERM CARE SETTING

The state of Washington is an innovator in long-term care provision, having been the first and only state to pass a public long-term care insurance program in 2019. In addition, Washington is an innovator in the use of assisted living and home-like care settings. Washington's long-term care sector is 72% for-profit, 21% not-for-profit, and the remainder government owned. Managed care penetration is high in Washington, with 94% penetration. The state's Medicaid program covers assisted living, and Medicaid reimbursement rate is just under the national average (98% of the national average). The average wage of a certified nurse assistant working in LTC in Washington is $14,62.

STATE COVID-19 OUTBREAK AND POPULATION LEVEL MEASURES

Washington was the initial epicenter of the COVID-19 public health emergency in the United States (US) in early March 2020, with the outbreak in the Kirkland Family Life Center nursing home facility. Ultimately, 46 people associated with the nursing home died. It is difficult to discern the number of positive cases at the facility because tests were so rare in the early days. One report indicated that 66 staff members showed symptoms in mid-March but only 1/6th were able to be tested (March 12). A strike team finally arrived by March 6 with tests for all residents.

Within ten days of the outbreak in Washington, the state issued a mandatory nursing home visitor ban (March 16, 2020). A day later schools were closed, and a week later stay at home / shelter in place orders were in effect (March 23, 2020). Immediately thereafter, on March 25, the state closed non-essential businesses. At the end of May the state relaxed the shelter in place orders.

At the end of our study period (end of June), there were 31,404 cases of COVID-19 in Washington State (Figure 1a). This rate included 2,894 positive cases among LTC residents and staff, or a share of 17% overall (Figure 1b). Overall, in Washington, 507 deaths from COVID-19 occurred as of the end of June, with over half (53%) of all deaths occurring in long-term care settings. This rate is higher than other states across the country.

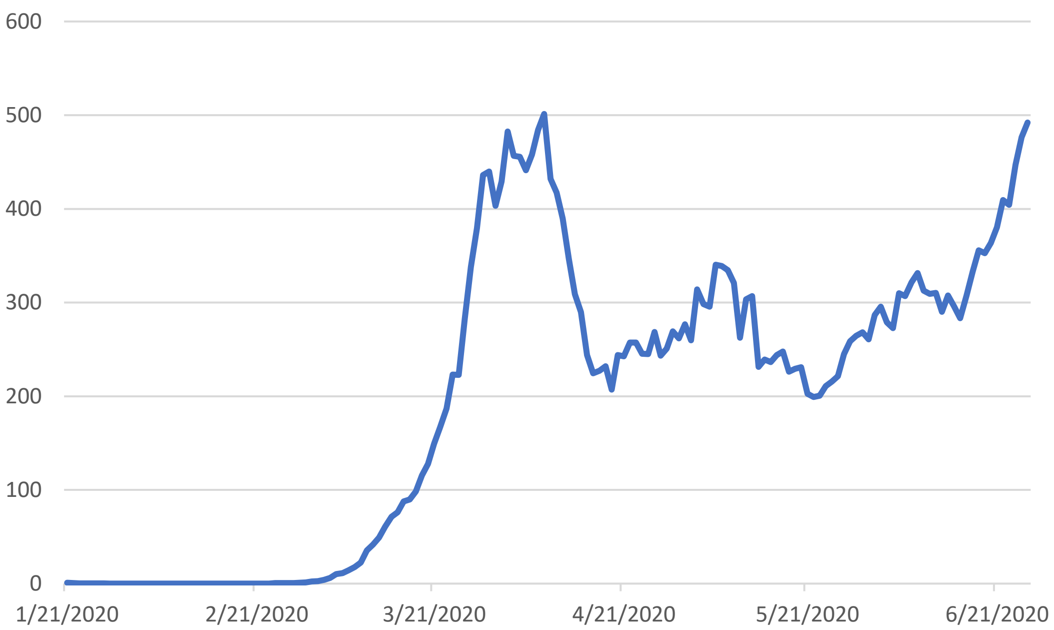
Figure 1B. Washington 7-Day Rolling Average COVID-19 Daily Cases
600
500
400
300
200
100
0
1/21/2020
2/21/2020
3/21/2020
4/21/2020
5/21/2020
6/21/2020

Figure 1B. Washington 7-Day Rolling Average COVID-19 Daily Deaths
30
25
20
15
10
5
0
1/21/2020
2/21/2020
3/21/2020
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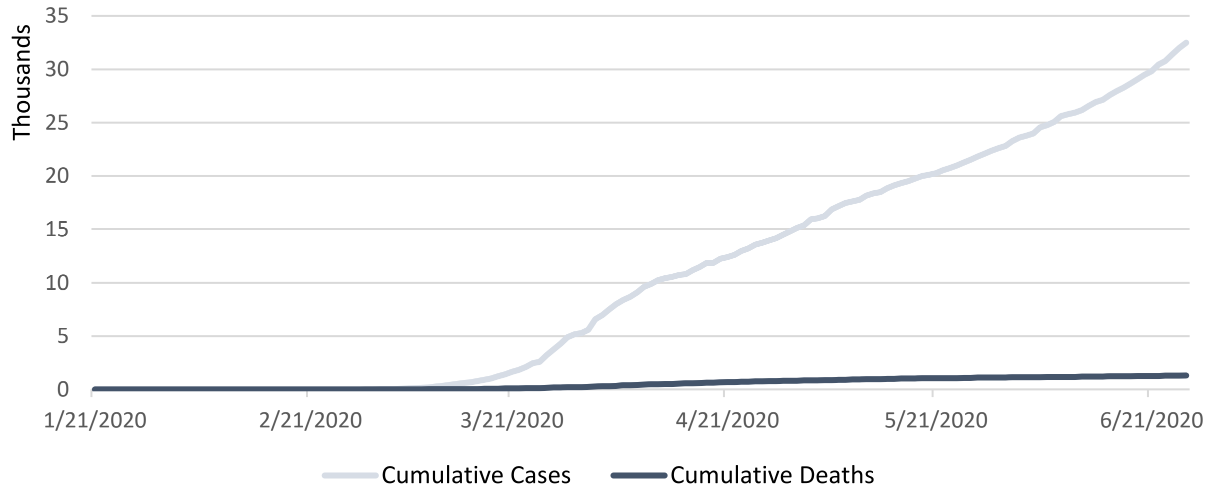
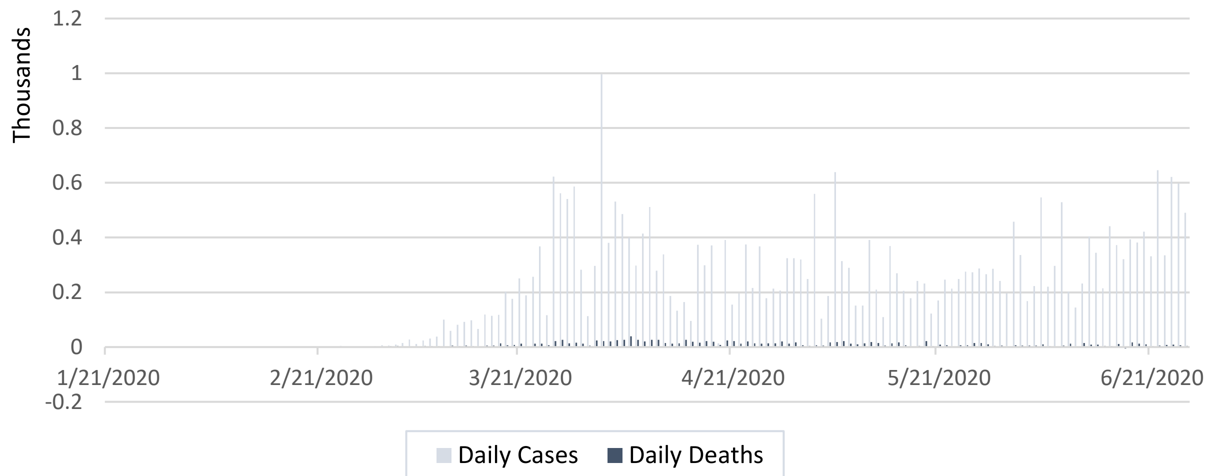




RISK MITIGATION STRATEGIES

Delays in testing: Testing was delayed after a first round of 850 test kits sent by the U.S. Centers for Disease Control and Prevention (CDC) on February 7th failed due to a faulty reagent. Replacements were slow to arrive and the WA state lab finally started conducting tests February 28. University of Washington Medicine Clinical Virology Laboratory, a Clinical Laboratory Improvement Amendments (CLIA) certified lab, developed its own COVID-19 test in mid-January in anticipation of the need; however, the FDA only allowing CLIA-certified labs to diagnose COVID-19 patients at the end of February. Because of a lack of testing supplies, facilities were required only to test residents and employees with symptoms, even in the face of growing evidence that asymptomatic and presymptomatic people can spread the disease.

On March 6, the Office of Public Health serving Seattle and King County, in collaboration with the CDC, recommended infection prevention and control measures, including isolation of all symptomatic residents and use of gowns, gloves, eye protection, facemasks, and hand hygiene for health care personnel entering symptomatic residents' rooms. On March 10, Governor Jay Inslee issued a mandate restricting visitation to one visitor per resident per day and requiring screening for symptoms of COVID-19 for visitors and staff before entering a facility. A data collection tool was developed to ascertain symptom status and underlying medical conditions for all residents. As of March 27, the testing strategy was still limited by inadequate supplies, including swabs needed for testing and packaging to transport the samples.

Washington was one of the first states to experience the surge, so they were able to acquire testing kits from other areas that were not yet experiencing a high number of cases. The Seattle Times identified 113 long-term care facilities in Washington state with residents or employees who tested positive for COVID-19 by April 16. Some LTC facilities received test kits from the University of Washington while others worked with out of state labs to acquire additional kits. Rapid results testing was available at some hospital systems in April, but these tests were prioritized for only the most critical-needs patients. April 16, the state announced 6,000 test kits were on hand, which contain a swab and a tube with a substance that preserves the sample, with another 10,000 on the way. In King County, the Seattle Flu Study provided 2,000 tests to health care workers in facilities and University of Washington Medicine donated some of the test kits it was able to get from China, 8,000 of which will go specifically to long-term care facilities.

As tests became more widely available, testing laboratories quickly reached capacity, resulting in long delays in getting test results. Early on, the UW lab handled the bulk of tests for Washington residents, but was overwhelmed as new demand began swell from other Northwest states. By mid-March, the UW lab tested up to 3,000 samples a day up from an initial capacity of 1000. From March 21 to April 3, lab turnaround times averaged one to five days.

In May, DOH Director John Wiesman issued Order 20-02 order requiring COVID-19 testing for all nursing home residents and staff by June 12th and in all assisted living facility memory care units by June 26th. The state will pay for staff tests, and insurance should cover tests for residents. However, Washington did not meet the deadline for completing broad testing of the 4,100 group care facilities, citing a shortage of testing supplies. Specifically, a shortage of shipping containers and cold packs has created complications for facilities looking to return samples to a lab for processing.

A COVID-19 outbreak in a long-term care skilled nursing facility (SNF) in King County, Washington that was first identified on February 28, 2020, highlighted the potential for rapid spread among residents of these types of facilities. on March 1, a second facility also had a positive test. nursing and administrative leadership instituted visitor restrictions, twice-daily assessments of COVID-19 signs and symptoms among residents, and fever screening of all health care personnel at the start of each shift. On March 6, Public Health – Seattle and King County, in collaboration with CDC, recommended infection prevention and control measures, including isolation of all symptomatic residents and use of gowns, gloves, eye protection, facemasks, and hand hygiene for health care personnel entering symptomatic residents' rooms. A data collection tool was developed to ascertain symptom status and underlying medical conditions for all residents. https://www.cdc.gov/mmwr/volumes/69/wr/mm6913e1.htm

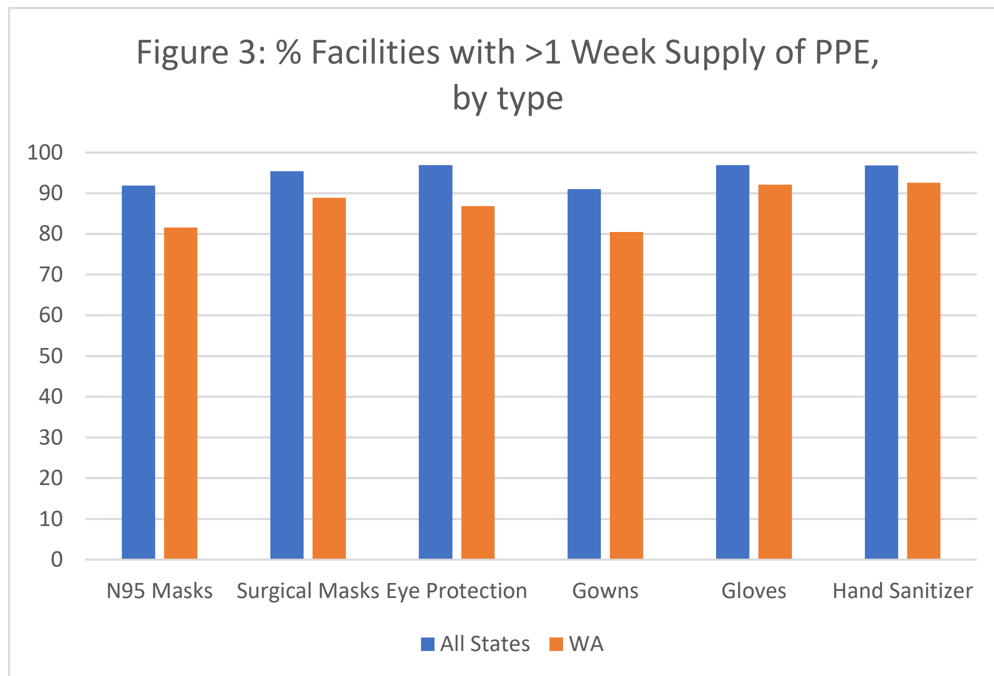
Initially told to only test residents and employees with symptoms, even in the face of growing evidence that people can spread the disease without them, because of a lack of testing supplies.

Supply of Personal Protective Equipment (PPE). Washington, like other states, has a multilevel government response to address PPE shortages at LTC facilities. Facilities that cannot secure an adequate supply of PPE may submit a request for PPE to local and tribal jurisdiction. In the event that the local authority cannot fulfil the request, the local authority then requests supplies from the state. (Source: https://coronavirus.wa.gov/what-you-need-know/personal-protective-equipment#meeting-ppe-needs) As of March 21 (https://coronavirus.wa.gov/news/department-health-releases-personal-protective-equipment-distribution-guidelines), Washington has set guidelines for prioritization of PPE requests that divide different requestors into tiers and LTC facilities have been given high priority, especially once cases have been confirmed (listing of LTCF entries from Source: https://www.doh.wa.gov/Emergencies/NovelCoronavirusOutbreak2020COVID19/PPEPrioritization):

- Tier #1: LTC facilities with confirmed cases and healthcare workers carrying out support to LTCF with confirmed cases (in addition to Hospitals with the highest number of confirmed cases)
- Tier #2 Other healthcare facilities with confirmed cases
- Tier #3 Skilled nursing facilities

Through May, due to limited supplies, the state was only able to distribute PPE to Tier #1 requestors. Into June, Washington began expanding to fulfill requests from other Tiers and by mid-August the state reported that most Tier #1 N95 respirators had been filled and most Tier 1-4 requests for KN95 respirators, surgical masks, and gloves had been filled. However, some items such as large size gowns and gloves and face shields still have unmet requests due to difficulty sourcing these specific supplies. (Source: https://coronavirus.wa.gov/what-you-need-know/personal-protective-equipment#meeting-ppe-needs)

Washington State has a public facing PPE Data website with information on source of PPE (purchases, donations, federal sources); vendors the state has made purchases from; and distribution of PPE. Data is provided by the Washington State COVID-19 Health System Response Management Team which was created in March to coordinate resources, including PPE emergency resource requests statewide (Source: https://www.cms.gov/files/document/covid-toolkit-states-mitigate-covid-19-nursing-homes.pdf)



In Mid-May, CMS began requiring facilities in all states to report COVID-19 information in the CDC's National Healthcare Safety Network LTCF COVID-19 Module which is then publicly reported at the facility level as the COVID-19 Nursing Home data set.

Source: CMS. COVID-19 Nursing Home Dataset. Latest week reported (June 14, 2020)

As of the week ending June 14, nursing facilities in Washington were more likely to report having less than a one-week supply of each of the PPE items included in the survey (Figure 3). 27% of Washington nursing facilities reported having less than a one-week supply of one or more of the PPE items (author's calculations from the COVID-19 Nursing Home Dataset, week ending June 14, 2020) illustrating that by mid-June, nursing homes in Washington were still experiencing significant PPE shortages.

Long delays in getting test results join a catalogue of shortcomings — from faulty test kits and onerous federal restrictions, to limited laboratory capacity and scarcity of medical supplies — that have plagued the nation's diagnostic testing response to the coronavirus pandemic. Early on, the UW lab handled the bulk of tests for Washington residents, as well as some for other Northwest states. It also quickly drew a flood of new clients. By mid-March, when the UW lab tested between 2,500 and 3,000 samples a day, it hit a capacity wall. Roughly 15,000 tests performed over the two-week period from March 21 to April 3, lab turnaround times averaged one to five days. Rapid results testing was available at some hospital systems, but these tests were prioritized for only the most critical-needs patients. As of March 27, 2020, one issue is limited supplies, including swabs needed for testing and packaging to transport the samples, but the situation is improving, at the time of this writing.

The Seattle Times identified 113 long-term care facilities in Washington state that had residents or employees test positive for COVID-19 by April 16, 2020.

In April 2020, Washington officials have also discussed taking more drastic actions, such as sending residents who test positive to designated facilities with dedicated staff, to keep them separate. Federal regulators and Inslee recently cleared facilities to transfer residents even if they appeal. At the time of this writing, cohort positive residents and require staff to quarantine for 10 days.

As of June 28, 2020, Department of Health guidance included to test all patients with symptoms consistent with COVID-19, and their close contacts even if they are asymptomatic. Additionally, health care providers are recommended to provide education and guidance to patients emphasizing the need to isolate for ill persons and self-quarantine for exposed contacts.

Director John Wiesman issued an order requiring COVID-19 testing for all nursing home residents and staff by June 12th and in all assisted living facility memory care units by June 26th. All testing conducted pursuant to DOH Order 20-02 will be funded by the state. The state will pay for staff tests, and insurance should cover tests for residents, Inslee said.

A robust supply of tests and PPE is needed for broad testing of the 4,100 group care facilities in Washington, which includes nursing homes and assisted-living facilities. Washington did not meet its goal of completing broad testing of most nursing home residents and workers for the new coronavirus, citing a shortage of testing supplies - a shortage of shipping containers and cold packs has created complications for facilities looking to return samples to a lab for processing.

Facility direct care changes

Washington has used a combination of cohorting and the establishment of COVID-only units to separate COVID-19 positive residents from the general nursing home resident population.

Cohorting: The Safe Start for Long Term Care Recommendations outline guidance for cohorting of residents that are symptomatic or with a positive COVID-19 test result. This specifies that space and staff should be identified to cohort and manage care for residents who are symptomatic or test COVID-positive. Additionally, each facility is required to have plans in place to manage new admissions and readmissions for people with unknown COVID-19 status and monitor residents who routinely attend outside medically necessary appointments such as dialysis. In order to move to Phase II, in addition to moderate community spread, facilities must have the ability to cohort residents and staff or be able to transfer positive /symptomatic patients to COVID positive facilities. An exception is made for small facilities which only need to be able to demonstrate a plan to follow guidelines for infection control, without cohorting or transfer.

(Source: https://www.governor.wa.gov/sites/default/files/LTC%20Safe%20Start%20NH-ICF-IID.pdf)

COVID-only wings: In early May, the Department of Social and Health Services (DSHS) announced that three facilities in the Puget Sound Region would have COVID specific wings with a total of 135 beds. These wings were established in larger facilities, all owned by Avamere Family Of Companies. To facilitate these dedicated COVID-only wings, the April 10 Governor's Proclamation 20-44 allows nursing homes to transfer residents to another long-term care facility even when a resident has appealed that transfer.

Transfer of patients between facilities: On March 24, Washington State Department of Health released Interim Guidance recommending that transfer of COVID-19 positive patients to long-term care facilities should be based on clinical care needs and not the need for transmission-based precautions. This guidance reflects the prioritization, in the early stages of the pandemic, of the need for COVID-19 patients to be discharged from hospitals when they no longer require acute care.

The current guidance, updated July 28, 2020, addresses transfers between long-term care facilities and other healthcare settings more generally. In general:

- The **transferring facility must** report the following to the accepting facility: COVID-status of resident being transferred; any COVID-19 cases at the transferring facility.
- The **receiving facility must** screen all patients and if coming from a LTC facility with cases or if symptomatic, must follow transmission-based precautions until testing is complete and results reported. Test results must be provided back to the LTCF.

For discharge of patients with unknown COVID status from a hospital to a long-term care facility, it is recommended, but not required, that the discharging hospital consider testing the patient prior to discharge and that long-term care facility should accept residents back from all healthcare settings regardless of COVID status, as long as the facility can provide the appropriate transmission-based precautions and appropriate level of care.

Even with this guidance, there were reports that nursing homes were refusing to accept hospital patients due to lack of preparedness as late as mid-May.

The Washington Department of Health COVID-19 Guidance for Long-Term Care Facilities, updated on March 24, recommends facilities develop an infection control preparedness plan that includes a "proactive sick leave policy to address the needs of staff." They specifically recommend that the plan should include contingency staffing and patient placement plans that include identification of minimum staffing needs and prioritization of critical and non-essential services based on the needs of residents.

In addition to this guidance, in March the governor also relaxed licensing requirements through two proclamations to help address staffing shortages in nursing homes. First, Proclamation by the Governor 20-32 suspends continuing education requirements for healthcare workers and allows retired licensees to practice in the state. Second, Proclamation by the Governor 20-37 suspends mandatory training and testing of Registered Nursing Assistants during the first 4 months of employment.

In late-March, Washington state began mandating insurance coverage for telehealth visits with healthcare providers, including for nursing home residents. The Governor issued Proclamation 20-29, effective March 25, 2020, which requires reimbursement parity for telehealth and in-person visits. Additionally, the state insurance commissioner issued Emergency Order 20-02 on March 24, 2020 allowing for the use of non-HIPPA compliant platforms for telehealth visits including telephone and video chat tools such as FaceTime and Skype.

LTC facility worker policy changes

Early outbreak highlights challenges of nursing home staffing. On February 27, 2020, a case was reported at the Life Care Center in Kirkland, WA. The virus quickly spread through the facility and "at one point, the Life Care Center had lost a third of its staff to the virus, with the remaining caregivers working 18-hour shifts." With a shortage of staff, the facility sought help from local providers, to no avail, as hospitals and other nursing homes in the area were trying to address their own staffing challenges. Eventually, the federal government was called on to deploy a strike team to support the facility. The team of 28 health care workers was comprised of physicians, physicians' assistants, nurses, technicians and other medical personnel. A retrospective study in the New England Journal of Medicine showed epidemiologic links between multiple facilities in the Seattle area and transmission via staff working in more than one nursing home.

Nursing home workers protest to demand hazard pay. On June 18, nursing home workers in Yakima, WA gathered to protest, demanding hazard pay. At the time, Yakima accounted for approximately 15% of total COVID-19 cases, but only represented 4% of the total state population. As workers demand increased pay due to the pandemic, the state is simultaneously facing a severe budget shortfall that could lead to reductions in long-term care funding.

Staff shortages remain a challenge in Washington. (Table 1) As of the week ending 6/14/2020, 27.7% of nursing homes reported some type of staff shortage, the most frequent of which were nursing aides,

with almost one-in-four nursing homes reporting a shortage. Just below one-in-five nursing homes reported a shortage of nurses.

Table 1. Reported Staff Shortages in Washington State

		Percent of Nursing Homes Reporting a Shortage
Any Staff Shortage		27.7
	Nurses	18.8
	Clinical staff	4.0
	Nursing Aides	23.8
	Other	10.4

(a) Source: CMS Nursing Home COVID-19 Data for the week ending 6/14/2018

Resident life changes

Nursing facilities restricted visitation to residents. On March 10th, the Governor restricted visitation to nursing homes and assisted living facilities through the amendment to Proclamation 20-05. Restricted visitation limited visitors to only adults passing COVID-19 screening wearing PPE, practicing social distancing and visiting in designated locations. Facilities were required to keep a log of all visitors. However, six days later on March 16th, the Governor issued proclamation 20-16 which restricted visitation completely except in the case of end of life visits. These restrictions also applied to assisted living facilities. Per guidance from the Washington State Department of Health issued April 4th, nursing homes are advised to suspend communal meals and cancel all group activities.

Facilities could request tablets to combat residents' social isolation. The Washington State Long-Term Care Ombudsman Program implemented a "Stay Connected" Campaign to provide Amazon Fire Tablets "to long-term facilities to be used to help residents stay connected to their loved ones". This initiative is funded through individual and corporate donors. In Washington, approximately 300 Long-Term Care Ombuds—most of them volunteers—advocate for the safety, health, welfare, and rights of residents in LTC facilities. On April 28th, the State also received "federal grant funding that will allow each long-term care facility to buy up to $3,000 worth of technology to assist during the COIVD response."

FINANCIAL SHOCKS AND STRATEGIES FOR RESILIENCE / REPORTING

Financing changes

Washington State provided and funded tests for residents and staff. Per Proclamation 20-02 issued on May 28th, the state provides testing to all residents and staff as well as PPE at no cost to the facility. Facilities are not obligated to pay laboratories for tests performed for residents or staff. Laboratories will be paid through CMS and Washington State Health Care Authority (HCA). For staff not covered by CMS, the state of Washington will pay laboratories for tests. As described above in testing, delays occurred in the testing and receipt of results.

Nursing facilities received enhanced reimbursement rates through multiple mechanisms. First, residential care services received rate enhancements by 12-15% by the increase to the Federal Match Assistance Percentages. Specifically, for Medicaid contracted providers, "admitting nursing home facilities will receive an exceptional rate of $100 per client per day atop regular rates for admitting a hospitalized client who transitions to their facility during the surge period. DSHS has also begun

establishing contracts with providers that can establish buildings or wings that can provide services dedicated to COVID+ residents. These COVID+ facilities will receive an enhanced daily rate of $450/day." Additionally, Washington state's 1135 waiver to CMS allowed flexibility in how Medicaid services and funds are allocated during the COVID-19 pandemic. Washington also waived prior authorization requirements for COVID-19 testing and treatment and expand telehealth services, including behavioral health services to be reimbursed at the same rate as in-person care. The Washington State HCA received over $4 million to expand behavioral health services to meet the growing needs during the public health emergency. In the first distribution of CARES Act payments, Washington state received just over $553 million funds through the CARES Act. Approximately $56 million went to skilled nursing facilities.

Finally, through proclamation 20-02, the state also extended a grace period regarding premium payments on insurance plans (for both individual and group health plans). [source: