November 14, 2022

Jeffrey A. Kraut
Chair, Public Health and Health Planning Council
Thomas Holt
Chair, Committee on Codes, Regulations, and Legislation
c/o Executive Secretary, Public Health and Health Planning Council
Empire State Plaza, Corning Tower, Room 1805
Albany, New York 12237

Re: 20-22 Amendment of Sections 405.11 and 415.9 of 10 NYCRR (Hospital and Nursing Home Personal Protective Equipment (PPE) Requirements

Dear Mr. Kraut, Mr. Holt, and members of the Public Health and Health Planning Council:

I am writing on behalf of the members of LeadingAge New York (LANY) -- non-profit and public providers of long-term and post-acute care services -- to offer comments on the amendment of sections 405.11 and 415.9 of 10 NYCRR (Hospital and Nursing Home PPE Requirements) which is on your agenda for both emergency adoption and final adoption on November 17.

We have offered extensive comments on these regulations previously and attach our most recent comments for your review. As previously noted, these regulations are outdated, do not align with the recommendations of the Centers for Disease Control, and are driving a waste of precious healthcare resources – both material and financial. The excessive amounts of PPE required by these regulations are forcing facilities to rent warehouse space and pile up boxes in areas of facilities that should be available for communal activities.

The excess amounts of PPE required by the Department are reportedly based on a Johns Hopkins study, conducted in April 2020. The study is available here: https://www.centerforhealthsecurity.org/resources/COVID-19/PPE/PPE-assumptions. The entirety of the study pertaining to nursing homes is reflected in the following text (pasted below) and a spreadsheet displaying the estimated PPE need for a 100-day wave of COVID-19 based on 1.5 million nursing home patients:

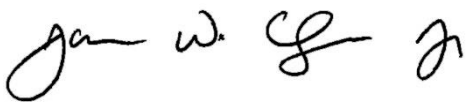
> PPE use in nursing homes
>
> We assume a 10% attack rate across 1.5 million nursing home residents in the United States.
> We assume COVID patients are cohorted.
> Gloves: 2 gloves for each of 12 changes per patient per day. This assumes a change with each patient encounter, as per normal practice by all healthcare workers.
> Gowns: Assumes that COVID patients are cohorted and that a single gown is worn for 4 hours by each healthcare worker assigned to the COVID cohort, unless it becomes visibly soiled. An average of 3 changes per visit.
> Simple masks: Assumes that COVID patients are cohorted and that a single mask is worn for 4 hours by each healthcare worker assigned to the COVID cohort, unless it becomes visibly soiled. An average of 1.5 changes per visit.
> N95 respirators: Not anticipated to be used in this setting.

As you can see, while the analysis provides assumptions about the number of changes of each type of PPE, it does not include any assumptions about the *point in time* that should be used for determining the COVID

positivity rate. Nor does it suggest that the use rates should be based on beds that are not in use – the methodology requires a calculation of use "per patient per day" or "per visit. " Notably, the analysis assumes that N95 respirators are not used in the nursing home – an assumption that has turned out to be mistaken. It seems that this analysis may be inadvertently misapplied in this regulation.

Thank you very much for your consideration of these issues.

Sincerely yours,



James W. Clyne, Jr.
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