May 4, 2020

Howard A. Zucker, M.D., J.D.
Commissioner of Health
NYS Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

RE: COVID-19 Return to Work and Cohorting/Transfer Standards

Dear Dr. Zucker:

I am writing on behalf of the mission-driven members of LeadingAge New York to raise serious concerns regarding the State's most recent approach to combatting COVID-19 in nursing homes and the new COVID-related work exclusion and cohorting and transfer standards announced on April 29th. These new standards were announced via two "Dear Administrator" letters (DALs), without any consultation with stakeholders or any understanding or appreciation of their feasibility or the negative effects they may have on nursing home residents. With the lives of vulnerable individuals at stake, health policy must be based on real world, practical conditions, formulated through collaboration not vilification, and implemented with appropriate planning and resources. To contain the spread of COVID-19 in nursing homes, our members need access to on-site testing and re-testing of all residents and staff, sufficient personal protective equipment consistent with sound infection control practices, and financial assistance and other supports to enable adequate staffing. In the absence of these critical elements, the DALs are likely to have little effect on the spread of COVID-19 in nursing homes and may actually do more harm than good. We ask that you immediately revise the April 29th DALs and develop, in collaboration with stakeholders, a comprehensive, multi-pronged strategy to provide nursing homes with the resources they need to care for their residents.

Like hospitals, the not-for-profit and public nursing homes in our membership, and the administrators, physicians, nurses, social workers, and aides who work in them, are engaged in selfless and heroic work. They are working long hours, under extraordinarily challenging conditions, to care for residents who are dear to them and who are particularly vulnerable to this devastating virus. They are striving to maintain a high quality of life in facilities that are their residents' homes, without the ability to carry on normal dining and social routines and without the comfort of family visitation. They are trying to soothe agitated residents with dementia who do not understand this disruption of their routines, who need the freedom to wander and to touch, who cannot tolerate wearing masks, and who are frightened of those who do. At the same time, the staff and the residents are grieving for the residents and co-workers they have lost to this deadly virus.

Notwithstanding their tireless devotion and the vulnerability of the older adults in their care, our nursing homes and their staffs are not saluted and are not prioritized for state and local support. Unlike many states that have increased funding and targeted staffing resources for nursing homes in response to the COVID emergency (e.g., Massachusetts, Maryland, Rhode Island, Connecticut, Oregon, Alabama,

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Washington, and Minnesota), New York has targeted nursing homes with impractical requirements, blame and investigations, while failing to provide the resources they need.

Moreover, by ignoring the shortage of PPE plaguing facilities, overlooking the lack of access to testing, and exacerbating staffing challenges, the two April 29th DALs may pose greater harm to residents than good. The DALs impose unrealistic standards and then require nursing homes to suspend admissions and transfer residents when those standards cannot be met. The logical outcome of these directives is either widespread displacement of hundreds of nursing home residents from the places they know as home, potentially against their will and causing them and their families great distress, or widespread violation of the standards due to lack of resources.

Specifically, the following factors render the DALs unrealistic and arguably more burdensome to residents than beneficial:

- Lack of Testing: The infection control DAL includes a requirement that nursing homes separate residents into three cohorts – positive, negative, and unknown – and assign dedicated staff to the positive and non-positive residents. There is no definition of the "unknown" category – we assume that it is composed of asymptomatic residents who have not been tested. CDC guidance recognizes that testing is integral to cohorting residents to separate those with COVID from those without detectable infection at the time of testing. CDC notes that when residents with COVID are identified, there are often asymptomatic residents with COVID as well, who can transmit the virus. Unfortunately, as the Department has acknowledged, testing is not readily available to nursing home residents or workers and certainly not on a regular basis. Absent a point prevalence survey of all residents and staff in a nursing home and regular re-testing,[1] "unknown" asymptomatic residents and staff will continue to transmit the virus, and cohorting is likely to be ineffective.

- Lack of Separate Staffing for Cohorts: The infection control DAL's requirement that nursing homes assign separate staff to COVID and non-COVID residents is infeasible in many nursing homes. Nursing homes are already struggling with absenteeism and staffing shortages. Their staffing is unpredictable, and unexpected absences of a staff member assigned to COVID-positive residents on one or more shifts may require a 'non-COVID' aide or nurse to attend to the COVID-positive residents. Moreover, outside of the New York City metropolitan area, many facilities will have only a handful of COVID-positive residents and will not be able to reliably assign their limited staff to care for what may amount to only a couple of residents. A small facility, for example, may have only one RN on-site for some shifts. In order to cohort residents, they will have to hire additional nurses. Even under the best of circumstances, nursing homes struggle to recruit and retain RNs. It is unrealistic to think that nursing homes will be able to significantly increase their staffing in the midst of a pandemic without substantial financial support from the state and federal governments.

- Return to Work and Staffing Shortages: While well-intentioned, the return to work DAL is impractical given the existing staffing shortages and will only exacerbate those shortages. By extending the work exclusion period from 7 to 14 days, and exceeding the 10-day exclusion period recently recommended by CDC, the State has further limited the supply of personnel eligible to work in facilities. Moreover, the guidance is so unclear that it is virtually impossible to implement. At what point does the 14-day period begin to run? On the day of the test or the

[1] Testing for Coronavirus (COVID-19) in Nursing Homes, https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html .

day the positive result is returned? Has the state abandoned CDC's test-based strategy of determining eligibility to return to work? Why?

- PPE Shortages: As the Department is well aware, there is a national shortage of personal protective equipment (PPE). Even nursing homes that are able to order PPE from vendors are finding that their supplies are intercepted by FEMA at ports of entry. Moreover, nursing homes are not at the top of the priority list in any county for PPE distributions from public supplies. Hospitals and first responders are first in line. And, supplies from public and private sources are unpredictable. While the recently announced state-run PPE inventory is appreciated, it has yet to be operationalized and there is little transparency on how it would work. Nursing homes do not know from week to week whether their delivery of PPE will satisfy their request and what supplies will be short. Despite the nationwide lack of consistently adequate supplies of PPE, the Department has directed nursing homes to suspend admissions and face possible penalties and license revocation if they fail to adhere to the Department's PPE standards. To threaten nursing homes with loss of licensure due to PPE shortages beyond their control is irresponsible.

- Transferring Residents: Notwithstanding the likelihood that cohorting without facility-wide testing and re-testing of residents and staff will be ineffective in preventing the spread of disease, the DAL requires facilities to transfer residents if they do not have the space or the staff to cohort residents. Presumably, these transfers must be effectuated even if residents and/or their families object, although we have received no guidance on how residents' refusals should be handled. Thus, without a strong clinical basis, residents will be moved away from their homes and familiar caregivers to different providers, regardless of their preferences. These unwanted transitions may lead to undesirable health outcomes as new caregivers must learn to manage the residents' medications, diets, emotional and behavioral needs, wound care, pain, etc. Furthermore, it is unclear where residents would be transferred. A facility that has adequate staff and PPE today might experience a shortage tomorrow.

A successful strategy to combat the spread of COVID in nursing homes will require active collaboration, sharing of ideas and expertise, and thoughtful problem solving, informed by facts on the ground, among the Department of Health, local health departments, nursing homes, and other stakeholders. To date, that level of collaboration and the resources needed to implement solutions have been lacking. Reducing the transmission of the virus in nursing homes will require a multi-pronged effort that includes widespread testing and re-testing on-site at nursing homes, prioritizing the distribution of PPE to nursing homes, and investment of funds in nursing home staff. We look forward to working with you to develop this plan and hope to hear from you or your staff this week to discuss how to move ahead with it.

Thank you for considering our concerns and recommendations.

Sincerely,

James W. Clyne, Jr.
President and CEO
LeadingAge New York

cc: Paul Francis

Megan Baldwin
Sally Dreslin
Mark Kissinger
Sheila McGarvey

LeadingAge NY represents approximately 400 not-for-profit and public providers of long-term and post-acute care and housing throughout New York State, including approximately 200 nursing homes and 80 adult care facilities.

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