Joint Senate and Assembly Hearing on COVID-19 and Long-Term Care

Testimony on behalf of LeadingAge New York
By:

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INTRODUCTION

On behalf of the membership of LeadingAge New York, thank you for the opportunity to testify on the impact of COVID-19 on our long-term care system and the residents and patients we serve. LeadingAge New York represents over 400 not-for-profit and public providers of long-term and post-acute care (LTPAC), aging services, and senior housing, as well as provider-sponsored Managed Long Term Care (MLTC) plans.

Our members are mission-driven organizations – they are not an industry; they are caregivers. They are acutely aware of the solemn trust placed in them by residents, patients, and families, and they accept that trust with unwavering dedication. The organizations that have lost residents, patients and staff to this virus have been devastated – the people under their care and their staff are members of a close-knit community, and every single life is precious. They welcome this opportunity to learn from the past four months and work with you and the Department of Health to develop policy initiatives that will mitigate the future impact of the pandemic on individuals who need long-term care services and the people who care for them.

It was well-known even before the COVID-19 outbreak hit New York that older adults and those with underlying health conditions were more vulnerable to infection and serious illness or death as a result of COVID. However, in the early months of the pandemic, the resources that were needed to curb the spread of the disease among people receiving long-term and post-acute care services were not available. There was a national shortage of personal protective equipment (PPE). COVID testing was barely available and was reserved for people who met narrow criteria. Government officials made decisions to prioritize hospitals for personal protective equipment, testing, and surge staffing; long-term care providers were not the top priority. Given the supply shortages and the rising infection rates, those priorities may have been reasonable. It is not our job to second guess well-intentioned decisions made in a crisis.

Today, with the first wave behind us and an opportunity to prepare for a second, the focus of policy-makers and regulators should be on developing the resources long-term care providers will need to mitigate the impact of the next wave. To prevent the spread of the virus in long-term care settings, we need consistent access to PPE, timely test results, and surge staffing. Unfortunately, long-term care providers still lack the resources they need to contain the virus when a second wave emerges. They are experiencing unstable PPE supplies and prolonged delays in COVID test results that are key tools to contain the spread of COVID. Without these resources, residents and staff cannot be protected from the virus, regardless of the rigidity of the lockdown requirements.

Long-term care providers need not only a stable supply of PPE and testing and consistent staffing, but also the financial resources to pay for them. However, the COVID-19 pandemic has exposed and exacerbated a longstanding depletion of public financial support for term care. For the past several years**,** long-term care has borne the greatest share of Medicaid cuts, despite a growing aged population and rising costs. Most Medicaid providers have not received inflation adjustments since 2008, despite rising costs – the median nursing home rate is $236 per day and the adult care facility (ACF) SSI rate is $41.75 per day. The exorbitant costs and plummeting revenues experienced as a result of COVID have destabilized an already under-funded long-term care system. Nevertheless, in the midst of the pandemic, New York carried out a 1.5 percent

across-the-board Medicaid cut, while 23 states and the District of Columbia raised their nursing home Medicaid rates or increased nursing home funding to support COVID response.[1] How can we expect our nursing homes and ACFs to provide a comprehensive array of services, room and board, and bear the added costs of weekly staff testing, PPE, surge staffing, hazard pay, and more at rates that are less than the price of a hotel room?

In addition to financial support, our nursing homes and ACFs need sensible policies that strike an appropriate balance between infection control and the health, well-being, and quality of life of their residents. Stringent lockdown directives may cause more harm to residents than good, leading to depression and physical deconditioning. The State's interpretation of the 28-day waiting period for visitation makes visitation unattainable for too many facilities and has raised hopes without providing meaningful and consistent access to in-person visits. We need a more flexible approach to social isolation and visitation that takes into account community spread, the unique features of individual facilities, and effective mitigation strategies.

We also need a sound approach to staff testing and return to work that is based on the scientific research. If nursing homes and ACFs are expected to spend tens of thousands of dollars each week on testing of every staff member, the test results must be timely enough to support effective infection control. If not, the labor, the record-keeping, the testing resources, and the money are wasted. And, if staff are to be tested weekly, the State must follow CDC guidance on returning to work. Persistent positive results of staff who have long ago recovered and completed multiple quarantines are contributing to staffing shortages, threatening the livelihood of entire households that must be quarantined too, and driving workers from the field of long-term care.

Like other states that have invested resources in long-term care in response to COVID-19, New York must implement policies that support high quality care and provide the necessary financial and operational support for long-term care providers. Sound policies and investments can help to avert problems before they arise.

The balance of my testimony will focus on the impact of COVID on our long-term care system, examples of heroism and recovery, the factors that led to widespread infection and high fatality rates in many nursing homes, and what we can do to mitigate the impact when the next wave hits.

I. LONG-TERM CARE HEROES

While our members, their staff, and their residents are grieving every lost life, it is important not to lose sight of the remarkable recoveries they have helped to achieve and the acts of heroism they have witnessed. I want to share just a few examples: Since the beginning of the pandemic, Gurwin Jewish Nursing Home in Long Island has celebrated 150 COVID recoveries. We've all

[1] As of mid June, 23 states and the District of Columbia had raised Medicaid rates for nursing homes in response to COVID or created supplemental funding pools to cover COVID-related expenses. They are: Alabama, California, Connecticut, Colorado, District of Columbia, Indiana, Georgia, Kansas, Kentucky, Massachusetts, Louisiana, Minnesota, Maine, Montana, New Mexico, North Carolina, Ohio, Oregon, South Carolina, Tennessee, Rhode Island, Virginia, Washington. (LeadingAge, "States Leverage Medicaid to Provide Nursing Homes a Lifeline through COVID-19," https://www.leadingage.org/node/63186 .)

read about "Miracle Larry Kelly" who recovered at the New Jewish Home in Manhattan after 51 days on a ventilator. At St. Catherine of Siena, Josephine Bonsignore recently celebrated her 102nd birthday after recovering from a battle with COVID-19.

These recoveries, the infections prevented, and the quality of life of all residents and patients are thanks to the dedication of the staff – aides, nurses, physicians, therapists, administrators, and more. Our members have shared countless reports of self-sacrifice for the benefit of the people under their care. Here are just a few examples of employees going above and beyond their normal duties:

- Katie Murphy Dedde, a mother of two young children, moved into an independent living residence on the campus of The Hebrew Home in Riverdale for over a month to ensure that the residents would have the supports they needed.
- Jennifer Tan, Chief Nursing Officer at United Hebrew of New Rochelle, went more than two months without kissing or hugging her two young children, her husband, or her mother-in-law, while she worked 12-hour shifts at the nursing facility and isolated herself in her home.
- Eustacia Smith, administrator of the West Side Federation of Senior and Supportive Housing's West 74th Street Residence, went three months without seeing her own children, so she could remain close to the facility and ensure the needs of her residents were met safely.
- Triciajean Jones, Director of Life Enrichment at St. Ann's, trained to be a Nursing Assistant, so she could pitch in wherever needed-all while providing meaningful social engagement to the residents.
- Joseph Girven, Executive Director of Carnegie East House, has been living at the enriched housing program since March, in order to avoid bringing the virus into his building during his daily public transit commute.

These are not unusual anecdotes. We've heard from many executives and direct care staff who moved into their facilities to avoid bringing infection in or out, and executives and staff who worked 12-hour days or more for months without a day off to protect residents and patients.

II. COVID-19 IMPACT ACROSS LONG-TERM CARE AND SENIOR SERVICES CONTINUUM

The devastating effects of COVID-19 have been felt not only by nursing homes and their residents, but by all long-term care and senior services providers and the people they serve. Nevertheless, providers have risen to the task of protecting the people under their care. The financial losses triggered by the pandemic are destabilizing these providers and jeopardizing the continued viability of needed long-term care and senior services resources. The following are some of the key impacts of the pandemic on the community-based continuum of care for older adults and people with disabilities:

Senior Housing. Our retirement housing and affordable senior housing members have been actively engaged in supporting socially-isolated seniors and educating them about the virus. They've provided home-delivered meals, virtual social events, and various concierge services; many focused on preventing or minimizing the devastating effects of social isolation on seniors.

They've worked with local governments and medical practices to arrange for testing of their residents and staff with varying degrees of success. They've spent exorbitant sums on disinfecting, masks, signage, and staff screening. These efforts likely prevented many senior housing residents from contracting the virus or needing higher levels of care.

Home Care. Our certified home health agencies (CHHAs) and licensed home care services agencies (LHCSAs), provide critical services that enable seniors and individuals with disabilities to live in the community. Moreover, they can provide post-acute and preventive services that help to avoid higher levels of care. They have struggled from the beginning of the pandemic to access the PPE they need to protect patients and workers. Agencies are also experiencing rising costs due to PPE, hazard pay, and sick pay needs along with shrinking revenues. At the same time, the State has declined to adopt certain federal flexibilities that would benefit CHHAs and their patients, including authorizing nurse practitioners to order CHHA services and in-service training relief. In addition, the State has issued policy directives to facilities concerning testing of home care agency and hospice staff that deliver care in nursing homes and ACFs without identifying a source of payment for those tests.

Medical Model Adult Day Health Care (ADHC): These programs were shuttered with five hours' notice on March 17th, and today remain the only health care provider that has not been authorized to re-open. ADHC programs provide skilled nursing services, therapies, personal care, and socialization to individuals with functional limitations and medical conditions that require skilled care. For many of their participants, the only alternative is a nursing home. In fact, after ADHC programs were instructed to close, many participants were forced to seek care in a nursing facility. For those who were able to substitute informal family care for some of their ADHC services, that option is evaporating, as family members return to work. If ADHC programs are not allowed re-open soon, they will be forced to shut their doors permanently, and we will lose a valuable community-based resource in New York State.

ACF/Assisted Living: ACFs and assisted living providers have been subject to nearly all of the rigorous COVID-related directives applied to nursing homes, despite the fact that they are generally a non-medical model with much lower reimbursement rates than nursing homes. They too have had to spend vast sums on PPE, staff screening and testing, disinfecting, and virtual resident engagement. For those ACFs that serve a low-income population, they have incurred these expenses, while receiving a Supplemental Security Income (SSI) rate of only $41.75 per day. As we discussed during our budget testimony, these ACFs were hanging by a thread before COVID-19, with an average of one facility closing each month over a recent 18-month period. For private-pay assisted living providers, payments come from the residents who are typically unable to absorb steep rate increases. Not only are costs rising, revenues are shrinking. Facilities are experiencing unprecedented vacancy rates because people don't want to move into a building where visitors and socializing are not allowed. And, because most ACFs do not provide Medicaid- or Medicare-reimbursed services, they have been ineligible for any of the federal provider relief funds. The worsening financial position of these providers is placing yet another community-based resource for senior care at risk.

III. NURSING HOMES: THE FIRST WAVE OF THE PANDEMIC AND LESSONS TO BE LEARNED

Nursing homes serve the most medically-complex individuals on the long-term care continuum -- those whose conditions require 24-hour skilled nursing care -- and their residents are at grave risk of contracting and succumbing to COVID-19 even in the context of perfectly-executed infection control and care. Eighty-five percent of nursing home residents in New York are over age 65, and 38 percent are over age 85. Ninety-seven percent of nursing home residents in New York require assistance with toileting, and forty percent require two people to assist with sitting up or turning in bed. Long-term nursing home residents also typically exhibit one or more chronic illnesses and serious comorbidities – including respiratory illnesses, circulatory conditions and diabetes. Over half of all nursing home residents have diagnoses of Alzheimer's Disease or other forms of dementia. Residents with dementia pose unique challenges in curbing COVID transmission, including wandering behaviors, fear of mask usage, and lack of comprehension or recollection of social distancing and its importance.

A. PPE, Testing, and Staffing Challenges

It is important to acknowledge that with a vulnerable resident population and staff and residents that come and go from the building, COVID infections in nursing homes (like COVID infections in the community) were inevitable and sadly will remain inevitable until there is a vaccine. Nursing homes cannot and should not be hermetically sealed off from the broader community. Nursing home staff live off-site and may be exposed to infection despite their best efforts to protect themselves and residents. Nursing home residents, even when subject to the stringent isolation directives of the past four months, must access health care services, such as dialysis and emergency care, in the community. Those who have family members and friends in the community need to see them and will do so off-site if they are not permitted visitors on-site.

The past four months have taught us that PPE and testing are essential to curbing the spread of COVID in nursing homes and throughout the long-term care continuum. During the first months of the pandemic, facilities' efforts to protect residents and staff were undermined by a lack of access to PPE and testing to support isolation, cohorting, and infection control. In March and April, long-term care providers could not obtain a regular supply of PPE at any price. Distributions from public stockpiles were initially denied or erratic, and often inadequate or defective. Nursing homes were third or fourth in order of priority for PPE. ACFs and home care agencies were initially told they were ineligible for public supplies because their workers did not need to get within 6 feet of patients and residents in order to care for them – a claim that was obviously incorrect. When supplies became available for purchase, prices were many times higher than normal. Inflated prices continue today – an N95 mask that cost $1.75 through our LeadingAge New York group purchasing organization before COVID now costs $6.50.

Due to the shortage of supplies, our members were instructed by health officials to use crisis conservation strategies for PPE, recommended by the CDC, that would not be the standard of care under normal circumstances. These strategies include, among others, reuse of facemasks and storage in a paper bag or breathable container. Providers were also instructed to keep PPE in secure locations to avoid excess use or misappropriation.

Not only did facilities lack the PPE needed to protect residents and staff, testing was not generally available for nursing home residents or staff to enable cohorting and effective staff screening. Initially, there was no reliable test, and when testing became available, it could generally be accessed only through hospitals and only for individuals who exhibited symptoms

or had an exposure. Moreover, without a test, COVID-19 was tricky to diagnose, especially in older adults. We understand that many older patients who were ultimately suspected of having COVID exhibited symptoms that were considered atypical in the early months of the pandemic, such as headache, dizziness, and gastrointestinal distress, rather than fever or cough.

At the same time, our members saw their staffs depleted by illness, family demands, and health concerns. They offered the remaining staff hazard pay and overtime, provided door-to-door transportation, and on-site meals. In some facilities, these measures did not alleviate staffing shortages. And, strong infection control practices required extra staff for cohorting, symptom screening, and other duties. Yet, nursing homes and ACFs were initially not eligible to access the surge staffing resources developed by the State. It was not until mid- to late April that nursing homes were invited to access the staffing portal and not until early May that ACFs were invited. Once they were given access, nursing homes and ACFs quickly learned that the health care workers who registered with the portal were seeking hospital jobs at higher rates of pay than our members could afford. Facilities in New York City did find some support, in mid-April, through a staffing contract implemented by the City that was tailored for nursing homes.

B. The Need for Collective Responsibility and Collaborative Learning

Much attention has been focused on whether nursing home residents who died after transfer to a hospital should have been counted as nursing home or hospital deaths. Without question, the death toll has been devastating and heartbreaking. But, the attribution of a death to one facility or another does little to inform the causes of death or the lessons that can be learned from it. There were hospital patients who were transferred to nursing homes to convalesce and died. Should they have been counted as hospital deaths because they originated in hospitals? There were likewise nursing home residents who were transferred to hospitals and died. Should these have been classified as nursing home deaths because they originated in nursing homes? Both facilities were responsible for their patients at different points in the disease trajectory. Both facilities may have prolonged the patient's life, both may have contributed to a tragic outcome, and both may have been powerless to heal a patient who was already at the end of his life before being stricken with COVID. A variety of patient-specific and facility-specific factors likely contributed to the result in every COVID case. The debate over attribution only serves to assign blame in a blunt, categorical way, without shedding any light on how future tragedies might be averted.

It is important to recognize that policies motivated by blame may discourage the delivery of needed services. At the height of the pandemic, there was tremendous concern that hospitals would be overwhelmed, and in NYC, several were. Government officials and the public were focused on preserving hospital beds for the most acutely ill. Despite crisis conditions, mission-driven nursing homes stepped up to deliver care to the most vulnerable, much as they have done for generations. They opened specialized COVID units and created surge space for hospitals. Had they refused to admit COVID patients from hospitals, this hearing might be focused on nursing homes that "exiled" their COVID-positive residents to distant facilities or that created bottlenecks in hospital discharge processes, while acutely ill patients languished in hospital hallways.

This drive to assign blame is also disheartening to the people who work in these settings, who have courageously gone to work each day, often times making tremendous sacrifices to do so. It is difficult for them to understand how hospital workers have been lauded as heroes, while people working in long-term care and post-acute settings are criticized and blamed. Their efforts have

been equally heroic and laudable. To attract dedicated people to work in long-term care and continue to provide high quality care to older adults and people with disabilities, we must elevate, not condemn, these professionals and paraprofessionals.

If we spend our time and resources attributing deaths and casting blame, we are losing a valuable opportunity to work together to develop our expertise and refine our practices. Hospitals, physicians, and long-term/post-acute care providers should collaboratively review COVID recoveries and fatalities among older adults and learn from them. This could improve outcomes going forward.

IV. STRATEGIES TO MITIGATE THE NEXT WAVE

With the pandemic surging around the county, we are likely to see a second wave in New York. We need to be ready to protect the most vulnerable among us – older adults and people with disabilities who require long-term care. The following are six actions that must be taken to mitigate the impact of the next wave:

1. Provide Financial Support

Historic under-funding and public disinvestment from the long-term care system have exacerbated the COVID crisis. Even before the pandemic and the exorbitant costs it brought, New York's median Medicaid rate of $236 per day for nursing homes fell $64 short of covering actual cost of care.[2] SSI rates of $41.75 per day for ACFs are even more shockingly inadequate. These rates are supposed to cover capital, food, staffing, and, in nursing homes, an array of medical and skilled nursing care. Moreover, the State has not provided a cost of living adjustment to Medicaid rates since 2008, even as providers have increased compensation annually, especially to nurses and aides, to retain and recruit high-quality direct care staff.

While many other states responded to the pandemic by raising Medicaid rates for long-term care providers, New York has responded with cuts. Almost all Medicaid providers are experiencing 1.5 percent Medicaid payment cut. This cut reduced Medicaid payments for long term care services by approximately $50 million in the first three months of CY 2020 and is set to slash another $300 million from Medicaid managed long term care, nursing home, home care and Medicaid assisted living payments in SFY 2020-21. On top of that, nursing homes face a $59.8 million (all funds) reduction in their capital reimbursement.

The financial position of many providers, especially not-for-profit providers, was shaky before COVID, and the situation is now dire. Costs have skyrocketed, and revenues have plummeted. A typical 200-bed nursing home spends about $30,000 weekly on staff testing. An ACF in our membership spent over $50,000 on five weeks of staff testing. It is unclear whether there will be any reimbursement of these testing expenses. Health plans and the union benefit funds have denied reimbursement, as the tests are administered for employment screening rather than

[2] Hansen Hunter & Company, "Report on Shortfalls in Medicaid Funding for Nursing Center Care," Nov. 2018. New York's $64 per day shortfall represents the largest shortfall of the 28 states the report analyzes.

medical purposes. Nursing homes are hoping for some reimbursement from FEMA, but FEMA has yet to indicate whether staff testing as it is conducted in New York is an eligible expense. Moreover, this source of funding is likely to be unavailable to ACFs.

PPE expenses have multiplied across the board. As noted above, the price of an N95 mask has increased fourfold. One large New York City nursing home reports $800,000 in additional PPE expenses due to the pandemic. On top of testing and PPE expenses, nursing homes and ACFs have spent or are spending significant unbudgeted amounts for hazard pay, paid sick leave, transportation for staff, and extra staff to support digital connections to loved ones, screening at the beginning of each shift, and supervision of visitation.

At the same time, nursing home, ACF and home care providers are experiencing dramatic drops in patient/resident census and, for nursing homes and certified home health agencies, significant reductions in Medicare revenue from post-surgery rehabilitation services, creating growing budget shortfalls. The statewide median nursing home occupancy, for example, had dropped by 12 percentage points by April, and has no doubt declined further since then. Statewide median figures mask the even more precipitous decline in nursing home occupancy in the downstate region, where nursing homes that typically operated at 90 to 95 percent occupancy are reporting occupancy rates of 60 to 75 percent.

As a result, it is not uncommon for our nursing home members to report COVID-related impacts from increased costs and revenue losses in the millions of dollars. One of our members, a respected 105-year-old, 5-Star, non-profit nursing home in Westchester, has announced that it is closing. While some critical relief was supplied through the federal CARES Act, for most providers hard hit by the pandemic, the funding received covers a fraction of the financial impact that they are experiencing. And, once again, ACFs are generally ineligible for this funding because they receive reimbursement through SSI or residents, rather than through Medicare or Medicaid.

Notably, while rising vacancies in nursing homes are causing financial distress for facilities, they are also driving Medicaid savings. We estimate that reductions in Medicaid days are creating state share Medicaid savings of approximately $45 million per month.

If we are to be ready for the next wave and preserve our long-term care capacity to care for our aging population, we need to stabilize the finances of long-term care providers. Providers need to pay for unprecedented staffing, testing, and PPE expenses. Moreover, they want to invest in specialized air circulation and filtration systems, disinfection devices, and telehealth. They cannot cover these expenses without adjustments to Medicaid and congregate care SSI rates.

2. Ensure Equitable Access to PPE and Testing

If and when the second wave emerges, long-term care providers cannot be relegated to third class status when PPE and testing resources are allocated. Nursing homes are working to muster the 60-day supply of PPE mandated by the State. Even now, however, the supply chain is unstable. N95 masks are difficult to procure, and gloves and gowns are in short supply.

Likewise, access to testing and timely results remains erratic. National labs are abandoning nursing home and ACF contracts, and testing supplies are sometimes unavailable. Test results are taking

longer and longer to arrive – many members from all regions are reporting lags of 14 days or more. By the time results arrive, an infected staff person could have passed on the infection to several co-workers or residents. Research indicates that prompt identification of an outbreak, typically in less than three days, is required for providers to coordinate an effective response. Nursing homes and ACFs are spending hundreds of thousands of dollars on staff testing which is worthless as an infection control measure if results are not reported timely.

To mitigate the risk of transmission in nursing homes and ACFs, and across the long-term care continuum, the State must ensure access to PPE, testing capacity, and prompt test results.

3. Support Investments in Baseline and Surge Staffing

Long-term care providers faced staffing shortages before the pandemic due to demographic and financial factors. We discussed the demographics in our budget testimony. And, the State's pricing systems for nursing homes, ALP and home care, which effectively pay all providers in each region the same amount for the same patient, regardless of how much the provider spends on its staffing, training, and quality improvement, contribute to the problem. Shortages have required reliance by many facilities on part-time, per diem and agency staff, who often work in more than one facility. This may have contributed to spread of the virus among facilities.

Staffing shortages are exacerbated by restrictive COVID-related return to work requirements for nursing home staff that exceed CDC recommendations. The State's nursing home return to work rules after a positive COVID test require multiple quarantines and furloughs when an individual receives persistent positive tests. This is commonplace and contrary to CDC guidance which concludes, based on several studies, that individuals who present with these persistent results are not infectious and that a symptom-based strategy for returning to work is preferable to a test-based strategy.

When staffing is under increased pressure, infection control efforts can be adversely affected. Cohorting and consistently assigned staff can be infeasible if a facility experiences widespread absenteeism. The State must invest in the long-term care workforce to ensure adequate staffing both for conventional conditions and pandemic surge needs. It should use its purchasing power and access to federal funds, as New York City did, to procure surge staffing for long-term care providers in the second wave. It must also ensure that its policies governing work exclusion are supported by science and don't do more harm than good.

4. Balance Infection Control Concerns with Quality of Life for Nursing Home and ACF Residents and Adult Day Health Care Participants

Nursing homes and ACFs offer health care services, but they are also their residents' homes. Our members strive to provide a home-like environment with opportunities for enriching social interaction, creativity, and community engagement. Today, they are struggling to provide a decent quality life for residents under directives that prohibit visitors, communal dining, and group activities. Stringent isolation directives have deleterious effects on residents, causing increased depression and agitation, deconditioning, and loss of appetite and cognitive abilities.

The rigorous lockdown requirements imposed by the State have also had the inadvertent effect of forcing residents to access the broader community at a greater risk to themselves and other

residents. Residents have the right to access the community for medical care, social engagement, hair care, and other needs. Since visitors, routine on-site medical visits, and beautician or barber contractors have been prohibited in the facilities, family members are bringing their loved ones into the community, exposing them to outsiders and returning them to the facility with potential infections.

The State should rationalize social distancing and visitation requirements in nursing homes and ACFs. It should also allow socially-distant group activities and routine on-site medical, dental and podiatric visits in facilities, based on factors such as community incidence and facility mitigation strategies, and regardless of whether the facility qualifies for visitation. Visiting health care practitioners would, of course, be required to satisfy screening and testing requirements. Similarly, hairdressers and barbers that meet screening and testing requirements should be permitted in facilities. Haircuts and styling are not frivolous luxuries. For older adults in long-term care settings, they are essential to dignity and morale. Offering social activities, health care visits, and visitation in the facility is safer for everyone than forcing residents to seek them off-site.

New York should re-think its visitation requirement of a 28-day waiting period after every new COVID case. This precondition is preventing most facilities from allowing visitors. New York's definition of COVID cases that trigger the waiting period is broader than the definition adopted by the CDC or CMS.[3] New York should instead either shorten the waiting period, or follow the federal guidance on nursing home visitation and exclude from the waiting period trigger those staff and resident cases that do not originate in the facility.

The State should also reopen medical model adult day health care programs. Individuals and families rely on these programs for skilled care and socialization. Adult day health care programs have submitted stringent reopening plans to the Department of Health that minimize infection control risks. By allowing participants to resume access to these services, the State can help to prevent further deterioration in the condition of participants and avoid the need for higher levels of care.

5. Weigh the Impacts of New Requirements, Audits, and Surveys

State and federal requirements related to the management of the pandemic have added significant administrative burdens on facilities that are already under financial and staffing stress. For example, nursing homes and ACFs report daily to DOH on their COVID cases and PPE and weekly on their staff testing. Nursing homes are also subject to slightly different federal requirements, in addition to the State requirements, governing family notification and COVID case and PPE reporting. At the same time, facilities have been experiencing infection control surveys and attorney general audits and receiving inquiries from local health departments. In addition, they are administering, tracking, and recording staff screening, testing and furloughs. They are constantly working to understand and comply with guidance that is rapidly evolving on matters ranging from infection control, to travel advisories, to sick leave. And, they are

[3] CMS recommends considering the "absence of any *new nursing home onset* COVID-19 cases (resident or staff), such as a resident acquiring COVID-19 in the nursing home" (emphasis added). New York requires the "absence of any *new onset* of COVID-19 among staff or residents as reported to the Department on the HERDS and staff testing surveys" (emphasis added). CMS's definition of the waiting period trigger excludes cases that originate outside the nursing home, while New York's definition does not.

managing virtual, window, and in-person visits where allowed. All of the existing requirements necessarily divert facility staff and resources from the delivery of direct care. Before any new requirements are imposed, policy-makers should consider the broader context and whether their value outweighs the diversion of resources from direct care.

6. Continue Immunity from Liability

The immunity from liability provision that was included in the State budget was a smart response to crisis conditions. It was sensibly drafted to cover only actions in good faith and in support of state directives. In a crisis, different standards of care are necessary. For example, during the pandemic, the State has prohibited routine medical specialty, dental and podiatric visits in nursing homes and recently allowed them to resume only if the nursing homes satisfies the stringent visitation criteria. This places residents at risk of various serious medical conditions. Likewise, CDC and other public health officials have encouraged the use of crisis conservation strategies for PPE, which they acknowledge deviate from conventional standards of care.

The crisis conditions that have prevented adherence to conventional standards have affected not only COVID-positive patients and residents. They have affected all residents of nursing homes and all patients of hospitals. The shortage of PPE, the delays in testing, and the suspension of routine medical visits affect everyone.

Health care professionals and aides, as well as facility executives, who are risking their own safety and the safety of their families during a public health emergency, should not have to worry about being sued while trying to deliver care under crisis conditions. We need these dedicated caregivers, and we don't want to discourage individuals from working in long-term care or acute care settings during emergencies. Imposing liability for actions taken in good faith under crisis conditions serves no legitimate policy goal and will likely have detrimental effects on residents and staff.

CONCLUSION

Now is not the time for casting blame on one party or another. The blame lies with the virus. Casting blame does not help patients, residents or workers. It does not improve the quality of care or strengthen the resilience of our health care delivery system. Now is the time for taking note of lessons learned and deliberatively and collaboratively planning for the next wave or the next emergency. Our patients and residents, our aides and nurses and doctors are counting on the State and local governments to take necessary and bold steps and work together with stakeholders in this effort. We offer our assistance in accomplishing these goals.

Founded in 1961, LeadingAge New York is the only statewide organization representing the entire continuum of not-for-profit, mission-driven, and public continuing care including home and community-based services, adult day health care, nursing homes, senior housing, continuing care retirement communities, adult care facilities, assisted living programs, and Managed Long Term Care plans. LeadingAge New York's 400-plus members serve an estimated 500,000 New Yorkers of all ages annually.