AGENDA

Assembly Budget Subcommittee No. 6 on Budget Process, Oversight and Program Evaluation

Assemblymember Phil Ting, Chair

WEDNESDAY, OCTOBER 28, 2020
1:30 PM, STATE CAPITOL – ROOM 4202

We encourage the public to provide written testimony before the hearing. Please send your written testimony to: BudgetSub6@asm.ca.gov. Please note that any written testimony submitted to the committee is considered public comment and may be read into the record or reprinted.

*Due to the statewide stay-at-home order and guidance on physical distancing, seating for this hearing will be very limited for press and for the public. All are encouraged to watch the hearing from its live stream on the Assembly's website at **https://www.assembly.ca.gov/todaysevents**.*

The Capitol will be open for attendance of this hearing, but the public is strongly encouraged to participate via the web portal, or one of the Remote Testimony Stations available for testimony outside of the Capitol (see locations below).

1. *Sacramento – State Capitol Park, North steps*
2. *San Francisco – State Office (455 Golden Gate Ave., San Francisco, CA 94102)*
3. *Fresno – Hugh Burns State Building (2550 Mariposa Street, Fresno, CA 93721)*
4. *Van Nuys – State Building (6150 Van Nuys Blvd., Van Nuys, CA 91401)*
5. *Los Angeles – Ronald Reagan State Building (300 South Spring Street, Los Angeles 90013)*
6. *San Diego – State Building (1350 Front Street, San Diego, CA 92101*

INFORMATIONAL HEARING
COVID-19 IN SKILLED NURSING FACILITIES

I. OPENING REMARKS

- Assemblymember Phil Ting, Chair
- Committee Members

II. COVID-19 IN SKILLED NURSING FACILITIES

- Heidi Steinecker, California Department of Public Health
- Lindy Harrington, Department of Health Care Services
- Michael Wasserman, MD, CMD, Past President , California Association of Long Term Care Medicine
- María Carmen, Bay Vista Certified Nursing Assistant, SEIU
- Nicole Howell, Executive Director, Ombudsman Services of Contra Costa, Solano and Alameda
- Charlene Harrington, Ph.D. RN, Professor Emerita, Department of Social & Behavioral Sciences, University of California San Francisco
- Craig Cornett, CEO/President, California Association of Health Facilities

III. MEMBER COMMENTS, QUESTIONS, AND DISCUSSION

IV. PUBLIC COMMENT

V. ADJOURNMENT

COVID-19 in Skilled Nursing Facilities
Background Paper

Since the start of the pandemic, COVID-19 has claimed the lives of 4,653 skilled nursing facility (SNF) residents as well as 152 health care workers employed in California's SNFs. As with the other 17,360 California lives lost to COVID-19, this represents thousands of families and loved ones whose hearts have been broken and lives changed forever. Unlike other Californians, however, this represents a case fatality rate from COVID-19 of approximately 17.2 percent as compared to approximately 1.9 percent in the general population. Over a quarter of all California COVID-19 deaths have been SNF residents/patients. The combination of very fragile health with congregate living settings has proven to be quite deadly in this pandemic, for which the state and nation were entirely unprepared.

This hearing intends to explore what we have learned, about COVID-19 in SNFs, from the first eight months of the pandemic and to answer questions such as:

- Are SNFs safer for residents and staff now than they were 3-6 months ago?
- Which interventions or policy changes have been most effective?
- Are we prepared for the next pandemic or the next "wave" of COVID-19?
- What else can and should we do to save lives in our SNFs?

This background paper covers a wide array of issues, related to these key questions that are the subject of this informational hearing, some specific to the pandemic, and others more general to the operation, quality, and financing of SNFs.

Data on COVID 19 in SNFs

The following charts and information were taken from, and is updated regularly, on the California Department of Public Health (CDPH) website:

https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/SNFsCOVID_19.aspx

As shown in the charts on the next page (which compare California to New York and Washington State), the case rate and fatality rate have declined considerably from their peaks in late April and again in late July. Specifically, the fatality rate (the percent of cases that result in death) peaked at 11.4 percent in mid-June as compared to the current 8.8 percent. Although the SNF case and fatality rates are much higher, the rate trends in SNFs track/follow the rate trends in the general population, i.e., general community transmission. The level of community transmission of the virus clearly impacts the case

rates within SNFs, and therefore the SNF rates follow and reflect the decline in community rates. Nevertheless, the decline in SNFs presumably also reflects a variety of changes and improvements to prevention and treatment efforts implemented over the past several months. The Subcommittee is interested in better understanding: 1) how well SNFs are able to protect residents and staff should the community case rates increase significantly in the coming months; and 2) what else can we do as a state to ensure that SNF fatality rates stay as low as possible in future COVID-19 spikes and future pandemics?

CALIFORNIA SKILLED NURSING FACILITIES

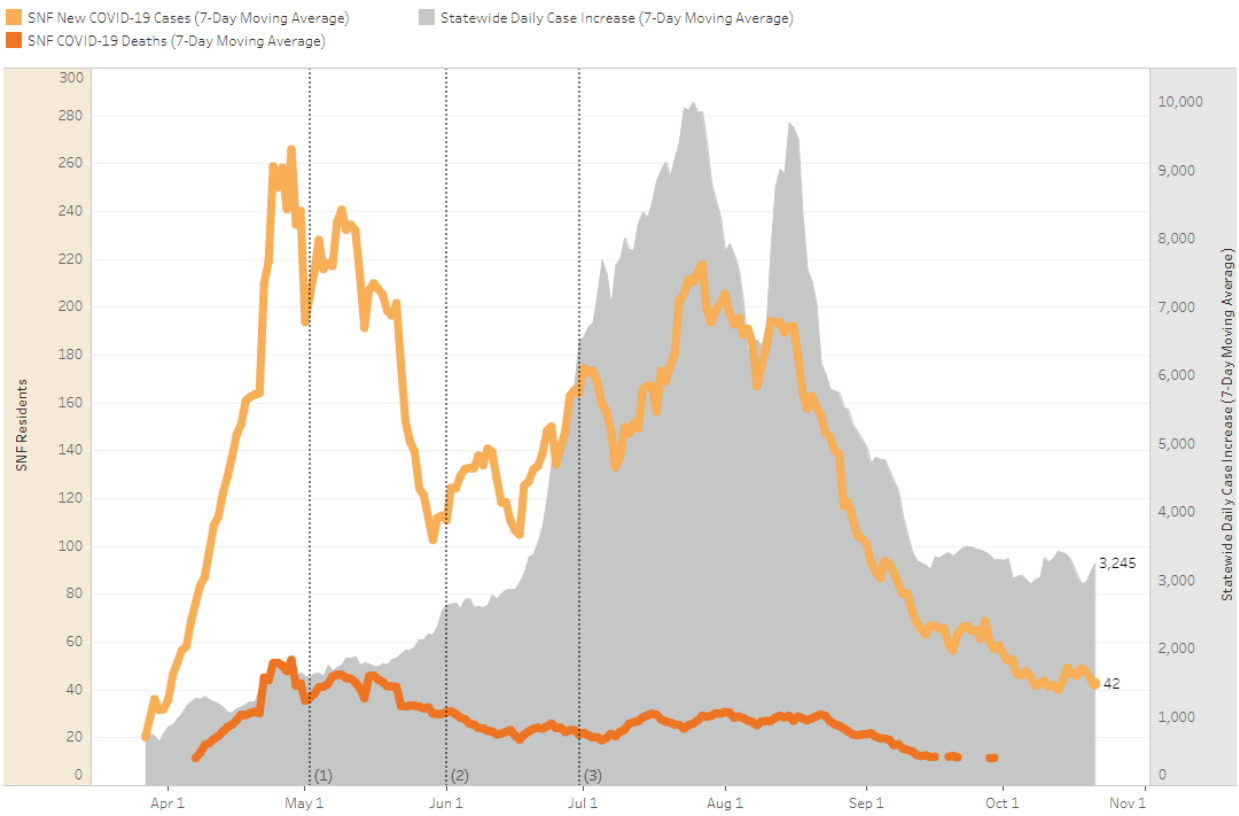
COVID-19 RESIDENT AND HEALTHCARE WORKER (HCW) CASES

LAST UPDATED: 10/23/2020 5:00:56 PM

DATE 10/22/2020

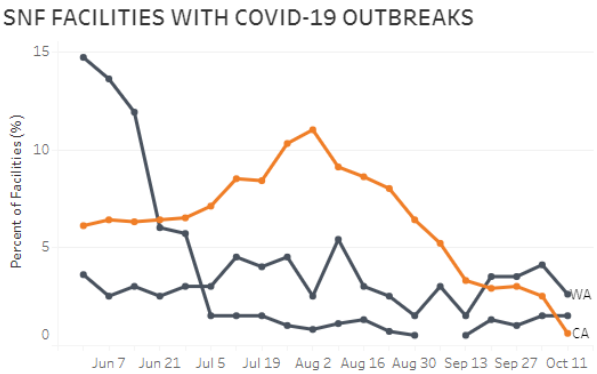
SKILLED NURSING FACILITIES	TODAY POSITIVE RESIDENTS	CUMULATIVE POSITIVE RESIDENTS	COVID-RELATED RESIDENT DEATHS
1,223	786 (+3.6%)	27,111 (+0.3%)	4,653 (+0.1%)
% REPORTING	**TODAY POSITIVE HCW**	**CUMULATIVE POSITIVE HCW**	**COVID-RELATED HCW DEATHS**
94.0% (+0.7%)	8 (-46.7%)	20,654 (+0.4%)	152 (+0.7%)

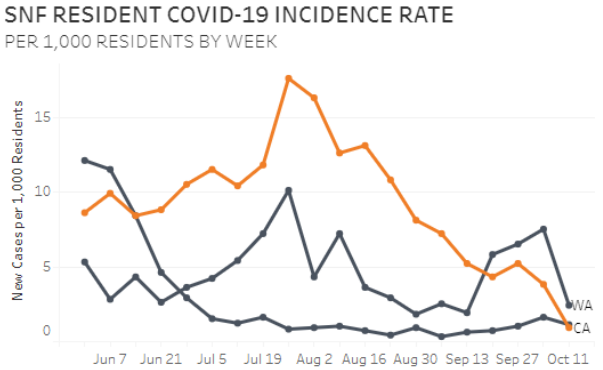
COVID-19 SKILLED NURSING FACILITIES TRENDS

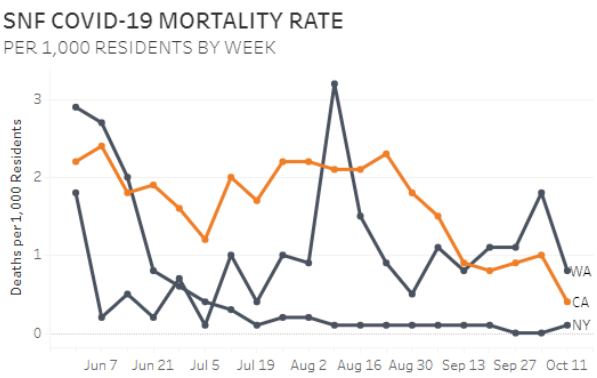


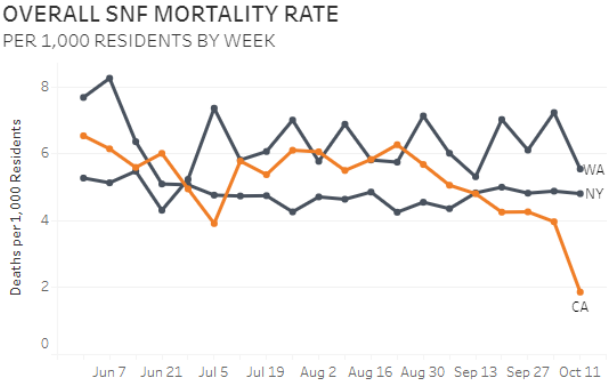
The following charts include data for California, New York and Washington. On the CDPH website (SNF COVID dashboard), one can manipulate these charts to compare California to any other states desired. It appears that, compared to other states, California is doing

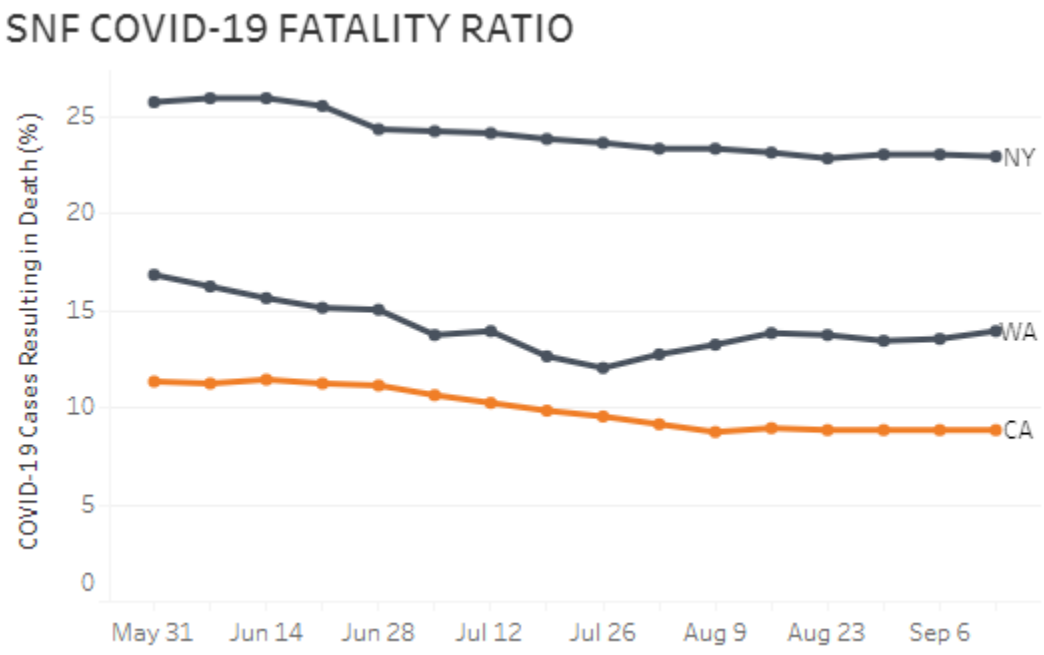
better than some and worse than others. I.e., California does not stand out as performing particularly well or poorly. Including Washington (where the first SNF outbreak occurred) and New York (where the impact of the virus was particularly severe) simply provides a point of comparison.











Infection Control

Some observers and experts argue that infection prevention efforts and requirements in SNFs were inadequate even prior to the pandemic. They argue further that the pandemic has served to magnify existing deficiencies in SNFs that affect infection control and quality

of care in general. Various infection control strategies have been instituted in SNFs during the pandemic, as required by either state or federal mandates. Some of these will be made permanent and will continue once the pandemic ends.

For example, prior to the pandemic, SNFs were required to have access to an Infection Preventionist (IP), but not on a full-time basis. A full-time IP in every SNF is a new requirement of the pandemic that has been made permanent through AB 2644 (Wood, Chapter 287, Statutes of 2020). AB 2644 takes effect January 1, 2021, however the California Association of Health Facilities (CAHF) states that most SNFs are close to having a full-time IP now given the pandemic requirements. Specifically, AB 2644 requires:

- In the event of a declared emergency related to a communicable disease, a SNF to report each disease related death to CDPH within 24 hours;

- CDPH to make the total number of disease related deaths reported, and the location at which they occurred, available on its internet website on a weekly basis and in a manner than protects patient's privacy; and

- Authorizes CDPH to require SNFs to report additional disease related information; require SNFs to notify residents and their representatives and family members about cases of the disease; and, require SNFs to have a full-time, dedicated Infection Preventionist.

Experts have also identified the practice of SNF workers working in multiple facilities as a risk factor for the spread of COVID 19. CAHF explains that this happens largely as a result of the fact that most SNFs can't afford to pay "overtime," and low wages drive people towards multiple jobs in multiple facilities in order to maintain well over 40 hours of work per week.

Personal Protective Equipment (PPE)

As is well-understood, California (as with the nation) has struggled to obtain sufficient supplies of PPE for every industry and population that needs it. Supplies were especially insufficient early in the pandemic, but have since largely caught up with the current demand.

According to CAHF, at the height of the pandemic, the severity of PPE shortages varied across counties and even across facilities, as certain facilities had unique access to various supply chains, and the priorities for distribution of PPE varied (and still varies) across counties. Thus, some SNFs experienced severe shortages of PPE while others did not.

CAHF now reports that currently there is no shortage of PPE across facilities throughout the state; however, it remains unclear if California has access to sufficient supply chains should COVID 19 rates spike over the next several months, as many national experts predict will happen nationally. Experts state that every SNF should have an abundance of PPE, such that PPE is never being reused or conserved. CAHF explains that reuse of PPE is strictly prohibited by the federal government at this point; nevertheless, this prohibition can't necessarily prevent it from happening if SNFs are facing shortages in the future.

CAHF explains that SNFs have significant concerns about and limitations to their capacity to store large quantities of PPE.

Questions for CDPH:

1. Is the state working on securing permanent increased supplies of PPE for SNFs, all other health care providers, and all industries that need it during future pandemics?

2. Is the state working on developing storage capacity for PPE, or are SNFs and others expected to provide their own storage?

3. Is the state working on a more equitable distribution system that would ensure adequate resources for all SNFs, as compared to the current system based on unique facility circumstances?

Testing

As with PPE, California (and the nation) has struggled with testing supplies and lab capacity. Testing capacity overall has increased significantly in recent months, resulting in much more testing (including in SNFs) and must faster test results. SNFs completed baseline testing of residents and staff by June 30, 2020 and reported all test results to local health jurisdictions and to CDPH. According to CAHF, residents are monitored daily and are tested if they present symptoms or have been exposed to a COVID positive resident or health care worker. Moreover, the Centers for Medicare and Medicaid Services (CMS) recently required all SNFs to test staff for COVID-19 on a weekly basis. Testing results are reported daily to CDPH and weekly to CMS/CDC.

Late in the summer, California's Testing Task Force released state priorities for testing, which placed SNF residents and staff in the second priority tier for testing. The Legislature would like to better understand the reasoning behind designating SNFs to the second priority tier given that the SNF population is likely the highest risk population in the state. Hospital discharges and transfers to SNFs remain a source of concern and contention. Early in the pandemic, CDPH issued guidance stating that a SNF could not deny admission to a patient based on a positive COVID 19 test. The Legislature would like to

better understand the rationale for this policy as well. Moreover, CAHF states that SNFs often feel pressured to accept patients being discharged from hospitals often when their COVID-19 test status is unknown.

Questions for CDPH or other Administration Representatives:

1. Are all surveyors, ombudspersons, and visitors tested prior to entering SNFs?

2. What is the rationale for not including SNF residents and staff in the highest priority tier for testing?

3. Is it still state policy that a SNF cannot deny admission to a patient based on a positive COVID-19 test, or pending test results? Is this consistent with national standards and recommendations?

Visitation Policies

In light of chronic staffing shortages in SNFs, relative and friend visitors have become a core component to SNF residents' lives and care. As a result, the pandemic prohibition on visitors has resulted in declining mental, physical, and emotional health for many SNF residents, and may have contributed to premature deaths for some.

According to CAHF, guidelines on visitors have been established by CMS and CDPH that are correlated to positivity rates within each county. The guidelines indicate that all visits should be held outdoors whenever practicable and indoor visitation is allowed only if there is no response testing or outbreak. Visits are conducted one at a time, movement is limited and visits are held in a single room or designated area. Core infection control principles must be maintained for visitation to occur, including screening, hand hygiene, source control, physical distance, signage, cleaning, staff PPE, designated areas and testing in place.

The limitations on visitation have extended to ombudspersons who play a critical role in ensuring the safety of residents. The Subcommittee would like to better understand the status of active involvement in SNFs by the State Ombudsman and local volunteers.

Questions for CDPH:

1. Please describe the overall level of personal visitation in SNFs, across the state, as compared to pre-pandemic levels.
2. Please describe the involvement of ombudspersons in SNFs, across the state, as compared to pre-pandemic levels.

Staffing Challenges

Advocates and experts have long called for increased staffing in SNFs, and link a higher quality of care to higher staffing ratios. National experts report that higher staffing levels improve resident outcomes, and therefore recommend a minimum staffing ratio of 4.1 direct care service hours per patient day. California law mandates a minimum staffing ratio of 3.5, which includes a minimum ratio of 2.4 specifically for certified nursing assistants (CNAs), and allows SNFs to apply for two types of waivers:

- Workforce Waiver – This waiver is for a SNF that is able to justify not meeting the required staffing ratio as a result of workforce shortages. This exemption is for one year and will be granted to a SNF no more than twice (for a total of two years).

- Patient Needs Waiver – This waiver is for a SNF with higher acuity patients, and therefore the need for a higher level of Registered Nurse (RN) and Licensed Vocational Nurse (LVN) staffing. These SNFs meet the overall minimum ratio of 3.5 but fail to meet the 2.4 ratio for CNAs.

Under normal circumstances (i.e., pre-pandemic), recruitment and retention of SNF workforce (primarily RNs, LVNs, and CNAs) is challenging for SNFs due to the following:

- Nursing workforce shortages;
- Higher wages for the same nurses offered by hospitals;
- Low wages for entry-level CNAs, coupled with very difficult work; and
- Limited accessibility to the required 160 hours of training required for CNAs.

According to CAHF, the pandemic has significantly increased staffing challenges for a variety of reasons, primarily fear, illness amongst the staff, and family illness caretaking responsibilities.

Questions for CDPH:

1. How many facilities currently have workforce waivers and how many have patient needs waivers?

2. Have requests for workforce waivers increased since the start of the pandemic?

3. In what ways has the state supported the availability of training programs for CNAs?

SNF Financing

The skilled nursing industry in California is comprised of approximately 1,200 facilities. Of those 1,200 facilities, only approximately 120 of them are nonprofit entities while the large majority are for-profit. The nonprofit SNFs most often offer a full continuum of senior care from low-level assisted living to skilled nursing, have a higher percentage of private pay

patients, engage in significant fund-raising efforts, and serve a much lower percentage of Medi-Cal patients as compared to for-profit facilities. The preponderance of for-profit facilities simply reflects the historical nature of the industry, according to CAHF. Non-profit and for-profit SNFs are all subject to the same government regulations and the same Medi-Cal and Medicare reimbursement rates. According to some experts, research has shown that for-profit ownership is associated with poor resident outcomes and quality.

The payer mix in SNFs is largely Medi-Cal which pays for approximately 66 percent of patient days, while Medicare covers most of the rest, and private pay insurance makes up only 1-5 percent of patient days. Medicare just covers short-term, often post-hospitalization rehabilitative stays, which makes up most of the patients at 84 percent. According to CAHF, the federal government strictly prohibits subsidization across government programs. Thus, the vast majority of long-term Medi-Cal SNF residents are in for-profit facilities for which the only revenue available to cover the costs of care for these patients is Medi-Cal reimbursement rates.

According to CAHF, Medi-Cal reimbursement rates do not cover the full cost of care for a variety of reasons. Medi-Cal reimbursement rates are based on costs, however a percentage is "shaved" off the top and costs increase annually at a higher rate than the annual increase in rates. Moreover, rates are based on two-year-old cost data. Finally, increasing labor costs do not automatically get reflected in rate adjustments, making it very difficult for SNFs to increase wages.

AB 1629 (Frommer, Chapter 875, Statutes of 2004) created a "Quality Assurance Fee" (QAF) for the SNF industry, thereby authorizing the Department of Health Care Services (DHCS) to assess a fee on facilities which is then matched with federal Medicaid dollars and returned to facilities in the form of higher Medi-Cal rates. Nevertheless, CAHF states that no significant profits are being made in this industry. According to the OSHPD LTC Annual Financial Data Profile for the 2018 calendar year, SNFs had an operating margin of 1.14 percent. According to CAHF, profit in this industry amounts to approximately $200,000 per facility per year.

AB 1629 has been reauthorized every 3-5 years since its inception in 2004, and generally governs the structure of Medi-Cal reimbursement payments to SNFs. The QAF was most recently reauthorized this year as part of the 2020 budget package through budget trailer bill AB 81 (Committee on Budget, Chapter 13, Statutes of 2020). AB 81 reauthorized and extended the QAF. Specifically, AB 81:

1. Extends the sunset on the QAF from December 31, 2020 to December 31, 2022;

2. Increases penalties, imposed by CDPH, on facilities for failing to meet the statutorily required direct care service hours per patient per day;

3. Authorizes DHCS to incorporate, under the Quality Assurance Supplemental Payment (QASP), an additional performance measure based upon a facility's compliance with COVID-19 requirements issued by CDPH;

4. Requires DHCS to pay a supplemental payment, by April 30 of 2021 and 2022, to qualified facilities based on statutory criteria and according to performance measure benchmarks determined by DHCS in consultation with stakeholders;

5. Discontinues the QASP on January 1, 2023, and requires DHCS to convene a stakeholder process by September 1, 2021 to develop a successor supplemental payment or similar quality-based payment methodology to replace the existing QASP, to begin in 2023;

6. Authorizes SNFs to account for the costs of caregiver trainings that enhance the skills, education, or career advancement for nursing home workers, and trainings provided through a joint labor-management Taft-Hartley fund, as direct passthroughs of proportional Medi-Cal costs;

7. Increases the limit on direct and indirect resident care labor costs from the 90th to the 95th percentile;

8. Requires DHCS to recoup any amounts of increased Medicaid payments that were not used to support the delivery of patient care;

9. Authorizes DHCS to condition a SNF's receipt of the annual rate increase for August 1, 2020 to December 31, 2020, and for the 2021 and 2022 calendar years on that facility's good faith efforts to comply with any requirements related to the COVID-19 Public Health Emergency described in CDPH All Facility Letters; and

10. Requires SNFs, beginning in 2021, to demonstrate compliance with the following Medi-Cal requirements: a) direct care service hours per patient day; b) applicable minimum wage laws; and c) wage pass-through requirements. Requires DHCS, when it determines that a facility has been out of compliance with any of these requirements, to assess a monthly penalty up to $50,000 until the facility demonstrates compliance to DHCS.

A 2017 audit of SNFs conducted by the Bureau of State Audits (BSA), "Skilled Nursing Facilities: Absent Effective State Oversight, Substandard Quality of Care Has Continued" (BSA 2017-109), included the following conclusion related to Medi-Cal payments and industry profits:

> "The sizes and net incomes of the three companies we reviewed have increased significantly over the past decade—even as the net income for the rest of the industry in the State decreased.

- Related-party transactions are common in the industry and are legally allowable.
- Though the companies paid between $37.2 million and $65.7 million to related parties from 2007 through 2015, most transactions were properly disclosed and Health Care Services ensured Medi-Cal did not pay for profits the companies realized from any of the transactions we reviewed."

Questions for DHCS:

1. Do you agree with CAHF that Medi-Cal payments do not cover the full cost of care for Medi-Cal patients/residents in SNFs?

2. Do you agree that SNFs could not afford to increase staffing substantially, or increase wages, without increased Medi-Cal payments?

3. How does DHCS provide fiscal oversight over SNFs? I.e., do you have sufficient financial data from SNFs to feel confident that Medi-Cal dollars are spent only on care for Medi-Cal patients and in accordance with all laws and regulations?

COVID-19 Federal Relief Funds for SNFs

As a component of federal pandemic relief, SNFs are currently receiving a ten percent rate increase for COVID-specific costs. This increase will continue until the end of the federal public health emergency. In addition to the AB 81 provisions described above, AB 81 also requires DHCS to audit facility costs and revenues that are associated with the COVID-19 Public Health Emergency to determine whether a facility has adequately used increased Medicaid payments associated with the emergency only for allowable costs, which include: patient care, increased wages or benefits, shift incentive payments, staff retention bonuses, pay differential for workers employed by more than one facility, and overtime payments to non-managerial workers, personal protective requirement, COVID-19 testing for any workers, infection control measures and equipment, and staff training.

CDPH Regulatory Oversight

CDPH licenses and regulates all health facilities, including SNFs, through their Licensing and Certification (L&C) Program within the CDPH Center for Health Care Quality (CHCQ). This function includes conducting surveys of SNFs to ensure full compliance with state and federal laws. It also includes investigations of complaints made by patients and facilities, for which there has been a significant backlog for many years. The administration and Legislature have sought to address this backlog of investigations through substantial allocations of new staff resources through the state budget over the past several years, as well as through policy bills that have strengthened and clarified deadlines for CDPH to complete various types of investigations.

New Survey Process

Discussed in more detail below, CDPH proposes to significantly reform its survey process by increasing SNF visits by surveyors from annually to monthly, and by transforming the role of the surveyors to that of an advisor to the SNF. Advocates are concerned that this creates a conflict of interest for surveyors, making their job as regulators very difficult. Advocates also point out that the administration has not indicated publicly that they plan to include resources for increased staffing in the Governor's January 2021 proposed budget, thereby leaving it unclear how this new workload will be managed.

In response to COVID-19, CHCQ has implemented a multi-pronged approach that includes a variety of strategies. According to the CDPH website:

> "CHCQ has worked to provide education and technical assistance to ensure that SNFs can implement necessary changes and actions. CHCQ surveyors have been onsite more frequently at SNFs during the COVID-19 pandemic to support SNFs on their infection control plans, and ensuring that those plans are fully implemented at the facility. When other actions are insufficient, enforcement actions are also an essential step to meet safety guidelines, have adequate resources, and protect residents' lives."

Additional ways CHCQ is working with SNFs during the COVID-19 pandemic include:

- Activating the Medical Health Coordination Center to have staff available 7 days a week to answer questions from SNFs and respond to resource requests;

- Issuing more than 55 COVID-19-specific policy guidance documents and All Facility Letters, which include requirements for COVID-19 Mitigation Plans, visitations, the SNF Toolkit, and specific critical elements like baseline testing;

- Hosting weekly All Facility Calls that average over 1,700 facility participants, to provide up-to-date information for testing, labs, infection control, and policies, as well as include a question-and-answer portion for state experts to answer real time questions and invite feedback;

- Retraining and redirecting 600 CHCQ health facility evaluator nurses to work alongside all SNFs to provide infection control education during onsite visits to help ensure safety of residents and coordinate solutions for staffing and personal protective equipment resource needs;

- Deploying strike teams to SNFs as necessary to assist in containing and mitigating outbreaks, conduct contact tracing risk exposure assessments, and coordinate testing with local health departments. CHCQ strike teams also assist SNFs with "cohorting," or separating residents who are COVID-19 positive and transferring

and receiving residents as needed. These teams include health facility evaluator nurses, infection control specialists, and staff from local health departments. CHCQ has deployed strike teams to over 400 SNFs since the pandemic began.

CDPH indicates that they are implementing six over-arching strategies to protect SNF patients and residents, including:

1. **Targeted COVID-19 Testing and Cohorting**. CHCQ required all SNFs to develop COVID-19 Mitigation Plans with six elements, including a plan for baseline, screening, and response-driven testing of residents and workers. CHCQ assists SNFs with access to testing as needed, including providing resources for testing labs and staffing options. CHCQ also provides technical assistance to SNFS for reporting testing data.

2. **Expand Statewide Infection Prevention Resources**. CHCQ has undertaken a statewide effort to increase the number of Infection Preventionist positions, develop dedicated infection prevention capacity in local health departments (LHDs), and increase the level and quality of infection prevention activity within SNFs. CHCQ also is pursuing additional state Infection Preventionists, who will be able to more quickly respond to serious infection concerns and provide proactive infection prevention support to all LHDs statewide. Finally, they are collaborating with LHDs to develop infection prevention support models.

3. **Infection Prevention Education**. CHCQ has developed an infection prevention education program that expands on the training of CHCQ surveyors, by focusing on evidence-based infection prevention care practices and current COVID-19 infection control guidance.

4. **Mobile Survey Application**. CHCQ is replacing its paper-based quality and safety oversight state survey process with an electronic mobile survey application developed by the University of California. This will allow all surveys to be automatically integrated into a data analytics dashboard for tracking of infection control and regulatory oversight. The mobile application will be implemented for all 11,000 health care facilities regulated by CHCQ, phased in based on prioritizing facilities at highest risk from COVID-19, therefore beginning with SNFs.

5. **Data Management and Predictive Analytics**. CHCQ implemented a dashboard -- an online enhanced daily reporting survey that collects critical information from SNFs on staffing levels, PPE, and staffing needs. This dashboard uses predictive analytics and modeling to project the spread and severity of COVID-19 in SNFs statewide. CHCQ uses this data to identify SNFs at high-risk in order to prioritize resources and conduct daily contact with these SNFs.

6. **Quality and Safety State Survey Model**. CHCQ is transitioning from annual state inspection surveys to increased on-site visits throughout the year to improve overall quality of care in SNFs, through frequent assessment and regulatory enforcement, and by providing more systematically recurrent feedback on non-compliance issues to SNF providers.

   Advocacy Concerns
   California Advocates for Nursing Home Reform (CANHR) submitted a letter to CDPH expressing a myriad of concerns about, and objections to, this new survey process proposed by CDPH. This letter is included as background (Attachment 1) for this hearing, and asserts the following:

   - The plan will divert the surveyor workforce from investigating complaints and other urgent priorities.
   - The plan's monitoring visits are described as supplemental to state re-licensing surveys, although legislatively mandated re-licensure surveys are not being conducted.
   - The plan is predicated on false assumptions.
   - The Department's revised duty statement presents an unreconcilable conflict of interest for surveyors.
   - The Department failed to consult with the Legislature or the public about the plan.

Vaccinations In SNFs
According to experts with the American Medical Directors Association (AMDA), it is not legally feasible or culturally acceptable to mandate vaccinations for either the SNF workforce or patients/residents. However, there is an established national goal for SNFs to reach 90 percent coverage of SNF workforce/staff with the flu vaccine. AMDA observes that generally residents are more amenable to vaccinations than are younger staff members, reflecting changing generational attitudes towards vaccines. AMDA states that despite industry efforts to encourage SNF staff to take the flu vaccine, coverage is estimated to be approximately 60 percent nationally. In order to ensure a successful future distribution and acceptance of any new COVID-19 vaccine by both patients and staff, AMDA recommends substantial and thorough planning and development of communications strategies to address patient and staff concerns, fears, and questions about the vaccine. There are extraordinary circumstances surrounding many SNF residents, such as dementia, that call for significant communication and coordination with family members as well. AMDA also states that it is critical that long-term care clinicians be directly involved in state and local vaccine distribution planning efforts.

Questions for CDPH:

1. Please respond to CANHR's concerns.

2. Specifically, please explain how it would not be a conflict of interest for a regulatory surveyor to act in an advisory role to a SNF.

3. Have you considered having surveyors play an advisory role who are different from those who would do survey work for any particular SNF?

4. Please provide a brief, high-level update on the status of the backlog of complaint investigations.

5. Please explain what resources will be needed for this new survey process.

6. Please describe the state's vaccine distribution planning efforts specific to SNFs.

See ATTACHMENT 1 on following page.

ATTACHMENT 1:

CANHR *Long Term Care Justice and Advocacy*
CALIFORNIA ADVOCATES FOR NURSING HOME REFORM

650 Harrison Street, 2nd Floor • San Francisco, California 94107 • (800) 474-1116 • www.canhr.org • canhrmail@canhr.org

October 5, 2020

Heidi Steinecker, Deputy Director
Center for Health Care Quality
California Department of Public Health
MS 0512, P.O. Box 997377
Sacramento, CA 95899-7377
By email to: Heidi.Steinecker@cdph.ca.gov

Re: Quality and Safety State SNF Survey Model

Dear Ms. Steinecker:

We are writing to urge the Department to withdraw the Quality and Safety State SNF Survey Model plan due to serious concerns about its development, purpose, viability, effectiveness and timing. The plan you sent to us on September 29, 2020 will divert a large part of the surveyor workforce from urgent legislatively mandated duties, including investigation of the enormous backlog of complaints on nursing home abuse and neglect. It was developed and finalized without any meaningful legislative oversight and no opportunity whatsoever for the public to review and shape it.

The undated executive summary you sent us on September 29 is the fourth in a series of illadvised plans to remodel the survey system that we have urged you to withdraw since you announced the Adopt-a-SNF plan to the Legislature during hearings on June 9 and 10.

The original Adopt-a-SNF executive summary (undated) stated that its purpose was to provide "collaboration, education, and technical assistance to SNF providers" through "daily check-ins, frequent trainings and weekly visits" by assigned surveyors. You testified that the Adopt-a-SNF plan would completely change and reform how nursing home oversight is conducted throughout California and then the nation.

Once we became aware of the Department's highly misguided plan to turn hundreds of CDPH surveyors into consultants to nursing home operators, we immediately urged you to withdraw the Adopt-a-SNF plan due to grave concerns about conflicts of interest that would compromise the Department's ability to enforce federal and state nursing home standards.

On July 14, you sent us a revised executive summary with a new name, Quality and Safety State SNF Survey Model. The undated plan stated that monthly visits from assigned surveyors would replace yearly state licensing surveys and provide more technical assistance to SNF providers. We responded in writing on July 16, urging you to withdraw the plan for a multitude of reasons: the plan was not legal, practical or properly designed; it threatened the integrity of the survey process; the middle of the pandemic is not the time to remodel state licensing surveys; and the plan is not what is needed now to improve resident safety.

On July 31, the Department sent us a revised executive summary that had a date of 7/23/20 in the document title (State SNF Quality & Safety Executive Summary 072320). The plan would assign surveyors to make monthly visits to engage in cooperative efforts with the steering committees of SNF QAPI (Quality Assurance Performance Improvement) teams. CANHR wrote you on
August 3 urging withdrawal of the plan, while raising objections that it had a false premise, was driven by providers, threatened the integrity of the survey process, was extraordinarily divisive and would institutionalize the Department's transformation of surveyors into guidance counselors to nursing home operators. We strongly objected to the highly inappropriate directive that surveyors engage with SNF operators on QAPI planning.

Notwithstanding our repeated requests to withdraw the plan and our serious objections to both the plan and the process used to establish it, the Department moved forward and produced the latest version, which you advised us is now final. CANHR has numerous concerns about the final plan and the process for developing it, including, but not limited to, the following:

The plan will divert the surveyor workforce from investigating complaints and other urgent priorities.

Making visits every four to six weeks to California's more than 1200 skilled nursing facilities will require more than 10,000 additional visits annually from a surveyor workforce that has never come close to carrying out the Department's existing mandates to oversee nursing homes. The plan provides no new positions or resources, making it inevitable that it will divert surveyors from recertification surveys, complaint investigations and re-licensure surveys, the foundational elements of the oversight system.

We are particularly concerned about the impact on investigations of complaints and facility reports of abuse and neglect. The plan directly questions their value, declaring that *"Periodic surveys to conduct complaint or facility reported incident investigations are also intermittent based on triaged priority and do not appear to have any real-time greater impact on overall long sustainable improvement."* To the extent there is any truth to this statement, it is an indictment of the Department's longstanding failures to investigate complaints and facility-reported neglect and abuse cases in a timely, thorough and effective manner.

It is beyond the purpose of this letter to detail our concerns about the Department's dysfunctional complaint investigation system, but you are certainly familiar with them. Abused and neglected nursing home residents often die before the Department investigates complaints about their mistreatment. Due to the long delays and the poor quality of investigations, the Department substantiates only one in five complaints and less than one in ten facility reports of abuse and neglect. Increasingly, the Department fails to take any action even when it substantiates complaints against nursing homes. As we documented earlier this year, the Department is closing thousands of substantiated complaints against nursing homes with a history of abuse without issuing deficiencies or citations. In doing so, the Department is constantly sending the message to nursing home operators that there are no consequences for abusing and neglecting residents.

According to the Department's most recent performance metrics data, the average age of open nursing home complaints statewide is 636 days. In Los Angeles County, the average age of open cases is an astonishing 1,121 days. The backlog of nursing home complaints and facility reported cases of neglect and abuse was 13,504 cases.

In 2015, the Legislature established timelines for completing nursing home complaints through SB 75 and funded hundreds of new positions requested by the Department to meet these mandates. The Department's 2015-16 Budget Change Proposal on this matter (4265-018-BCPDP-2015-GB) provides this statement on "Outcomes and Accountability."

"The CHCQ estimates that with the 237 positions requested in this Budget Change Proposal, program staff could complete the current pending investigation workload in approximately four years, while also addressing new workload and avoiding any new cases from aging. After the existing aging complaint and entity-reported incidents investigations have been completed, staff will focus on reducing the average time needed to complete investigations and on increasing the frequency of periodic surveys."

Five years later, the Department is not complying with the complaint investigation timeliness standards set in SB 75 (codified at Health and Safety Code §1420) and it still has a scandalously large complaint backlog.

Immediately prior to the pandemic, we urged you to address the failures of the complaint system and to engage consumers and the public in transforming the Department's troubling "Debt Free 2021 Campaign" into a campaign to make nursing homes "Neglect and Abuse Free." The urgent need to do so has only grown since the outset of the pandemic, with the public desperate for meaningful and timely interventions to the dangerous conditions in nursing homes that have killed and harmed so many residents.

It is beyond our understanding how the Department can redirect its resources to a new oversight system without having fixed its failing complaint investigation system as the Legislature directed. California nursing home residents will not be safe from neglect and abuse until the Department establishes a system that investigates complaints and facility reported cases of neglect and abuse in a timely, thorough and effective manner. We strongly oppose diverting resources from that mission.

The plan's monitoring visits are described as supplemental to state re-licensing surveys, although legislatively mandated re-licensure surveys are not being conducted.

According to the plan, *"Routine Quality and Safety Oversight periodic inspections are not intended to replace CMS recertification surveys, other CMS directed investigations or State relicensing surveys."*

Yet, the Department is conducting only a small fraction of the re-licensure surveys at long-term health facilities mandated by California Health & Safety Code §1422. Through the third quarter of FY 2019-20, the Department's performance data reports it conducted only 18 percent of the mandated re-licensure surveys. During the same period in Los Angeles County, **zero percent** of long-term health facilities received legislatively mandated re-licensure inspections.

In FY 2018-19, prior to the pandemic, the Department reports conducting re-licensure surveys at only 35 percent of the long-term health facilities that were required to receive them.

The plan is predicated on false assumptions.

The lessons the Department reports it has learned from the pandemic are highly questionable, including the following justification presented in the plan.

The Mitigation Surveys served as the pilot for the Q&S Survey Model to increase the frequency of CDPH's presence in SNFs. One of the lessons learned in this pandemic is regardless of where the SNF is located, the size of the SNF, the compliance history of the SNF, or the actions taken by CDPH at the SNF, the most critical difference is frequency in which CDPH surveyors and HAI are onsite. Even though California case rates continued to soar upward in summer, and the numbers of hospitalizations surged in late summer, the SNF case rate remained stable, and SNF resident death rates decreased since the beginning of the pandemic and have since stabilized. Taking this model and applying it to broader compliance monitoring will result in long-term better outcomes for SNF residents.

CANHR does not question the value of surveyor presence in skilled nursing facilities. However, we strongly dispute the Department's narrative that its initiatives spared California nursing home residents from death and harm during the pandemic.

No amount of whitewashing can disguise the fact that over 4,500 California residents and over 150 health care workers at skilled nursing facilities died from Covid-19. Many more residents have died from poor care and extreme isolation. Nearly 50,000 residents and staff members have been infected. All involved and their families have suffered immensely. CANHR has been flooded with calls from people who are enduring heartbreaking tragedies in nursing homes that have failed to keep residents safe. The Department's indifference to their suffering is appalling.

As a public health agency, one would hope that the Department would know better than to characterize the horrific death toll as a success story.

The self-serving nature of the Department's conclusions only raise doubts about their legitimacy.

The Department's revised duty statement presents an unreconcilable conflict of interest for surveyors.

You advised us that the revised duty statement is final notwithstanding SEIU Local 1000's Unfair Practice Charge and that the duty statement does not change the role of HFEN surveyors despite the fact that it requires them to spend thirty percent of their time advising and assisting operators on regulatory matters.

Neither of these claims is credible, especially given the Department's failure to repudiate the plans it touted throughout the summer that surveyors would be required to provide additional collaboration, education and technical assistance to SNF providers.

We fully share the Union's and surveyors' concerns about the fundamental conflicts of interest the Department has created for surveyors and the harmful impact this conflict will have on their ability to properly enforce nursing home standards and to protect residents' rights. The revised duty statement threatens the integrity of the survey process.

Nursing home operators have many other options for obtaining advice on regulatory matters that do not involve the inherent conflicts created by the Department's duty statement and plan.

CANHR is also deeply troubled by the Department's dismissive attitude toward frontline surveyors who have raised concerns that the Department is putting the interests of nursing home

operators above those of residents. We have heard from surveyors throughout California who share these concerns. It is to their credit that they are speaking out on behalf of residents whose needs and concerns appear to have been abandoned by the Department.

The Department should collaborate with residents on their safety, not appease providers.

The plan describes the monitoring visits as "a professionally cooperative approach between the facility and the surveyor," it requires surveyors to engage with leadership of the facility, and it makes the outcome of facility evaluations a measure of success of the surveys.

The plan's language reflects the Department's misguided orientation that SNF operators are their customers, and that its surveyors are expected to satisfy operators' expectations. Unscrupulous operators take advantage of this troubling dynamic, which undermines surveyors' abilities to hold facilities accountable when residents are mistreated or neglected.

In contrast, the plan is silent on engaging with residents or their representatives. Their views are not sought on the surveys or on the quality of their care. The Department should be taking its cues from residents and their representatives, not nursing home lobbyists.

The plan is not needed to expand monitoring.

The Department has existing authority to monitor nursing homes as often as it deems necessary to ensure the health and safety of residents. Indeed, CANHR has often called on the Department to monitor facilities operated by entities that the Department has determined to be unfit.

The Department failed to consult with the Legislature or the public about the plan.

It is hard to imagine a less transparent process than the one the Department used to develop this plan. Given its significance to the health and safety of nursing home residents and the dire conditions they face right now, one would think that the Department would have engaged in an open process where anyone who is interested could learn about its oversight proposal and express their views on it. That certainly has not been the case.

There has not been a single public meeting on the plan. To this day, we don't know who the Department has consulted or what views they have expressed. Any discussions the Department may have held with stakeholders have been held in silos.

Nor has there been any meaningful legislative oversight, which certainly would have been triggered had the Department been transparent about the impact of redeploying its surveyor workforce from legislatively mandated duties. It is remarkable that the Department has not developed any budget analysis of the plan or any other briefing documents that examine the plan's impact on its duties and workforce.

What has been apparent is the Department's agenda to reward nursing home lobbyists by inhibiting surveyor independence and promoting the industry's fallacious narrative about a punitive survey system. These are long sought goals of nursing home lobbyists. It is no surprise that providers characterized the Department's plan and duty statement as "Christmas in July."

The incredibly divisive plan is not what is needed now to protect resident health and safety.

It is profoundly unwise to adopt such a controversial plan in the midst of the pandemic.

With respect to nursing home oversight, what's needed now is to restore regular recertification and life safety code surveys, to give urgent attention to current and backlogged complaints and facility reported cases of abuse and neglect, and to increase monitoring of facilities and chains with poor performance histories and those facilities at the earliest signs of outbreaks.

This recommendation reflects our great concern that surveyors have performed very little assessment of individual resident quality of care and quality of life during the pandemic because the Department redirected them to very narrowly focused infection control and mitigation surveys. Refocusing inspections on resident concerns and outcomes is long overdue.

Outside of the survey process, CANHR has made numerous reform recommendations to the Department. We urge it to act on them.

Once again, we strongly urge you to withdraw the plan and the revised duty statement. Thank you for your consideration.

Sincerely,

Michael Connors
Advocate

Patricia McGinnis
Executive Director

cc: Honorable Gavin Newsom, Governor of California Mark Ghaly, Secretary, Health and Human Services Agency
Sandra Shewry, Acting Director, California Department of Public Health
Tam Ma, Deputy Legislative Secretary, Office of Legislative Affairs
Honorable Adrin Nazarian, Chair, Assembly Aging and Long-Term Care Committee
Honorable Jim Wood, Chair, Assembly Health Committee
Honorable Richard Pan, Chair, Senate Health Committee
Senate and Assembly Budget Committees
Steven Chickering, Associate Regional Administrator, CMS