Immediate Actions Pennsylvania Must Take to Address the COVID-19 Crisis in Long-Term Care Facilities

PA Advocates for Improved COVID-19 Response in LTC Facilities

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August 2020
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II. Introduction

Since March 6, 2020, when Governor Wolf issued his first Executive Order declaring a disaster emergency in Pennsylvania due to the COVID-19 pandemic, Pennsylvania has taken many evidence-based steps to address the spread of COVID-19.

Notwithstanding these initiatives, the COVID-19 pandemic has had drastic and tragic effects on Pennsylvania’s long-term care residents and the staff who care for them. More than 4,700 long-term care (LTC) residents have died because of the COVID 19 virus, 68% of all deaths in Pennsylvania. Although the Administration has taken some steps to address the needs of residents of LTC facilities, additional action must be taken to respond to the specific needs of LTC residents and to protect this vulnerable population.

This position paper is presented by consumer advocacy organizations: Center for Advocacy for the Rights and Interests of the Elderly (CARIE), Community Legal Services of Philadelphia (CLS), Alzheimer’s Association, Delaware Valley Chapter, Alzheimer’s Association Greater Pennsylvania Chapter, Center for Independent Living of Central PA, Disability Rights PA (DRP), Pennsylvania Association of Elder Law Attorneys, Pennsylvania Health Law Project (PHLP), and SeniorLAW Center.

Collectively, we counsel and represent and/or advocate for long-term care residents and their family caregivers, including the particularly vulnerable low-income, Medicaid-funded residents, many of whom are people of color. We offer this paper to urge Pennsylvania to take additional, specific actions to address the crisis that currently exists in the Commonwealth’s long-term care facilities. These facilities – which include nursing facilities, assisted living facilities, and personal care homes - vary in size, location, quality compliance, and philosophy. They are each governed by their own separate set of regulations. Together, these facilities house over 122,000 Pennsylvanians with disabilities and chronic conditions. Despite the differences between them, LTC Facilities share the mandate to properly care for their residents.

The chaos of the COVID-19 crisis has illuminated the vulnerabilities of LTC facilities. Infection control failures and staffing shortages are just two of the longstanding problems that impact the quality of care our loved ones receive in an LTC facility. Couple these long-standing problems with the crisis of COVID-19 and the result has been far worse outcomes than the virus alone would have caused. Additionally, early COVID-19 data is already demonstrating stark racial disparities in COVID-19 outcomes for LTC facility residents, revealing another reason to address racial equity through structural reforms to the LTC system. Low-income, Medicaid funded residents also experience the adverse impact of COVID-19 in disproportionate numbers as compared with their non-Medicaid funded peers.

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1 Pennsylvania nursing facilities, assisted living residences, and personal care homes are collectively referred to as long-term care facilities in this position paper. Long-term care residents refers to the individuals who reside in a Pennsylvania nursing facility (NF), assisted living residence (ALR), or personal care home (PCH).
There is much to learn from academics, experts, and other states about steps for preventing, detecting, and treating COVID-19. There is also much to learn about supporting staff and facilities, monitoring and overseeing infection control and other regulatory compliance, as well as preventing the adverse effects of isolation and disconnectedness.

This position paper first describes what PA has done to date around COVID-19 and LTC facilities. Then, it outlines our recommendations for immediate action based on what other states are doing and what experts are recommending.
III. What PA has Done to Date

The Wolf Administration and the Pennsylvania General Assembly have taken the following actions (as of the date of this position paper):

- Made the state public health laboratory available for COVID-19 testing where timely commercial testing is not available;
- Made antibody testing available for first responders;
- Issued Orders requiring nursing facilities to report data on COVID-19 cases among staff and residents, and published this data on the Department of Health’s website;
- Contracted with ECRI, Inc. to provide infection prevention and control assistance to high risk facilities;
- Partnered with the Jewish Healthcare Foundation and seven health systems to create the Educational Support and Clinical Consultation Program (ESSCP), a learning collaborative which has provided clinical guidance, advice on infection control strategies and clinical needs identification to long term care facilities;
- Issued numerous clinical Health Alert Notices (HANs), guidance and resources to LTC facilities and conducted calls with LTC facilities;
- Issued guidance establishing a gradual process to reopen nursing facilities to visitation by family and friends;
- Made over 2,300 pushes of Personal Protective Equipment out to LTC through public/private partnerships and collaboration, including more than 306,944 gowns, 336,559 face shields, 1,023,800 gloves, 2,807,570 N95s masks and 1,175,200 surgical masks.
- Mandated baseline testing of all residents and staff by 7/24/20 for nursing facilities and by 8/31/20 for personal care homes and assisted living facilities;
- Provided $245 million in CARES Act funding to nursing facilities and $50 million in CARES funds for personal care homes and assisted living facilities;
- Contracted with health system partnerships to implement the Regional Response Health Collaboratives2 (RRHCP), as established by Act 24 with $175 million in CARES Act funding to provide operations, management and administrative support to long term care facilities for the time period ending 12/1/20;
- Established the PA COVID-19 Hazard Pay Program, through which long term care providers can apply for grants to be used to provide a $3 per hour pay increase between 8/16/20 and 10/24/20 for staff earning less than $20 per hour;
- Issued a Hand Washing Audit Tool; and
- Deployed 69 Pennsylvanian National Guard Strike Teams to 34 different LTC facilities. This work includes 32 site assessments, 10 PPE trainings, 13 COVID-19 mass testing missions, and 14 facility staffing missions.

Despite these actions, in just one month, between June 8 and July 10, 2020, 605 additional LTC residents died of the virus, 621 LTC staff testified positive, there were 1,997 more total infections identified, and an additional 122 LTC facilities experienced infections.

III. Recommended Immediate Actions

Our recommended immediate actions are based on best practices in other states and experts’ recommendations.

National experts are making recommendations to improve the outcomes for nursing facility residents and staff. Additionally, other states’ policies provide learning opportunities for Pennsylvania. The following is a list of recommendations that must be considered for long-term care facilities in PA, including some examples from other states that are implementing them, if any.

A. Residents’ Rights

Residents’ Rights Recommendation #1
Reiterate to LTC facilities that residents’ rights must continue to be honored during times of crisis, such as COVID-19.

Pennsylvania must ensure that residents’ rights are not violated. Incorporating a restatement of rights into any guidance or policy is important for conveying the importance of ongoing rights as well as for reminding facilities they are expected to continue to honor them.

Residents’ Rights Recommendation #2
Ensure the right to high-quality, person-centered care, even during an emergency, like COVID-19.

This especially is important to those who are even more vulnerable in long term care settings, like people with dementia. They have unique care needs that fluctuate daily, challenging staff to pivot care delivery. Multiple staff changes further challenge this population to remain calm and maintain routines, which is important to this population. New staff may not understand unique care needs and how to effectively communicate with those living with dementia to appropriately support them. The Alzheimer’s Association issued emergency preparedness guidance for staff in LTC and community-based settings to care for those living with dementia, which could be disseminated.³

Residents’ Rights Recommendation #3
Impose a moratorium on all involuntary LTC facilities discharges and transfers.

³ https://alz.org/media/Documents/COVID-19-EmergencyTips_LongTermCommunityBasedDementiaCare_AlzheimersAssociation.pdf?_ga=2.36316768.1981629519.1594738192-907121422.1589573716&_gac=1.208921254.1592567374.EAiaQopChMln72U-ueN6gIVkonCh0zw6DEAAYASAAEgLNSPD_BwE
Pennsylvania must immediately issue a mandate prohibiting any involuntary discharges or transfers from any LTC facilities during the COVID-19 pandemic. This has been repeatedly recommended by our coalition members and national advocates for LTC facility residents.\(^4\) There can be no justification for permitting LTC facilities to evict residents and endanger their health with the risk of COVID-19.

**Residents’ Right Recommendation #4**

Require facilities to honor resident rights related to transfers, to provide appropriate notice of transfers, and to consult with residents and their families about transfers as far in advance as practicable.

The state must require facilities to honor a resident’s transfer rights, including the right to notice and consultation before any transfers between settings as far in advance as practicable, the right to return, and the right to have person-centered service plans when transitioning to the new facility. This includes the obligation to communicate about any moves related to cohorting of residents by COVID-19 status. Notwithstanding an urgent need to cohort, which we support in Prevention Recommendation #5, below, LTC facilities must inform and seek to accommodate residents as much as possible during such fearful times.

Additionally, for many residents there is a need for essential caregivers to aid with transfer trauma/delirium. The state should make available support from the Long-Term Care Ombudsman Program.

**Residents’ Rights Recommendation #5**

Issue guidance to LTC facilities on visitation that 1) ensures compassionate care visits earlier than the last few hours of life and for reasons other than end of life, 2) requires admission of essential caregivers who follow staff protocols for entry and infection control, and 3) eases visitation restrictions by replacing them with structured visitation protocols, limits, or requirements.

Pennsylvania must develop visitation guidance with the input of residents, families, and advocates to outline protocols that support residents and permit visits. The guidance must be coupled with a robust testing and re-testing strategy.

Visitation restrictions were initially necessary but have also had adverse effects on residents and their loved ones. Since the coronavirus will continue to be a threat, the state must permit safe resumption of visits with protections and precautions instead of continuing the social isolation.\(^5\) Recognizing the importance of in-person care,


\(^5\) Recommended by: CANHR - CA Advocates pressing for planned easing of visitation restrictions because of isolation.
connection, the goal is to permit a new kind of visit with protections and restrictions instead of wholesale prohibition of all visits except compassionate visits.

Several states and countries have successfully restored visitation. Australia has adopted reasonable procedures to allow for visits and reduce isolation while maintaining infection control standards.6

A recent small-scale study in the Netherlands shows it is possible to allow visitors in LTC facilities with precautions, even facilities with active cases of Covid-19. The study demonstrated a significant increase in resident wellbeing with no additional cases of COVID-19. The results of this study led the Dutch government to model study guidelines to reopen nursing facilities to visitors throughout the country.7

We support a policy that allows visitors with precautions, procedures, and restrictions instead of one that restricts all visitors with limited exceptions. Examples of provisions PA’s guidance could include are:

- Funding access to rapid point of care testing for all residents, staff, and visitors.
- Screening measures such as temps and pulse oximeter reading before entry.
- Hand sanitizing.
- Access to, and proper donning and doffing, of needed PPE.
- Controlling numbers of visitors and essential caregivers.
  - Limiting the number of visitors a resident can receive at any one time (e.g. one or two);
  - Limiting the number of different visitors a resident can receive a week (e.g. one or two);
  - Limiting the number of visitors in the care home at any one time; and,
  - Limiting the length of visits.
- Controlling entry and exit. Establishing rules designating a single point of entry and a single (possibly separate for infection control purposes) point of exit as well as for movement throughout the home.
- Using the outdoors.
- Designating selected rooms for visitation that are well-ventilated and well sanitized between visitors.
- Mandating preparatory steps prior to allowing entry into a resident’s room such as opening windows, bringing in a portable HEPA air filtration system, designating a specific chair/part of the room for the visitor to use, checking that the resident is properly masked, etc. and outlining requirements for cleaning and sanitizing after the visit.

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In addition to visits within the facility, outdoor visits should be encouraged and facilitated whenever possible, as meeting outdoors adds additional safety measures. Weather permitting, these visits could provide needed contact and socialization for residents.

**Residents’ Rights Recommendation #6**

Require facilities to make contact with and provide updates to COVID+ residents’ families at least once daily and to make contact with and provides updates to COVID- residents’ families at least weekly or more frequently if there is any change in the status of the resident, staff, or facility.

Pennsylvania must set minimum standards for friends and families that are cut off from their loved ones due to the pandemic but who are desperate for information and updates.\(^8\)

**B. Detection**

Pennsylvania must do more to detect COVID-19 within LTC facilities. In order to detect COVID-19 for prompt treatment, Pennsylvania must adopt more stringent measures than those currently in place. We recommend the following:

**Detection Recommendation #1**

Require the COVID-19 testing of all LTC residents and staff and mandate timelines, periodicity, and protocols in an evidence-based, re-testing strategy.

Testing cannot just be one snapshot in time. Pennsylvania should adopt measures to require and pay for ongoing testing of residents and staff at meaningful intervals. State policy currently only calls for a one-time test for COVID-19 (unless there are COVID positive individuals in the facility) without requiring regular re-testing.\(^9\)

The frequency of retesting should be no less than weekly for staff and residents with detailed requirements outlined by the state and taking into consideration both the rates of COVID-19 in the community in which the LTC facility is located as well as the presence of the virus in the facility. CMS has begun requiring weekly testing of all nursing facility residents and staff in states with a 5% positivity rate (or greater).\(^10\)

We recommend:

- Daily pre-shift and mid-shift screenings for staff.
- Daily screenings for residents.


• Testing all staff to establish a baseline and then retesting staff every 3-7 days with the actual intervals and frequency for each LTC facility to be determined in relation to the community prevalence rates of the virus.11
• Testing all residents to establish a baseline and then retesting residents in the event of any outbreak, which is defined as the occurrence of any single staff or resident positive case of COVID-19, which would prompt a full-scale retesting of all residents.

The state must immediately adopt, implement, and enforce a policy for ongoing testing of LTC facility staff and residents.

Detection Recommendation #2
Provide, pay for, and support facilities in administering COVID-19 tests.

We urge the state to fund, provide, and assist in administration of COVID-19 tests. Pennsylvania must ensure access to its labs if needed to ensure timely results. Available tests must be prioritized for LTC facility staff and residents, where the risk of mortality outmatches any other setting or population. While the RRHCPs are expected to assist facilities with securing testing, their work is time-limited. Come December, the state must have implemented plans to ensure sufficient testing to satisfy a robust testing and re-testing strategy.

The state should explore creative public-private partnerships to make these tests available, similar to the partnership between CVS/Omnicare and the state to administer 50,000 tests in nursing facilities statewide in Pennsylvania.12

For example, the state could:

• Call on the state’s numerous pharmaceutical companies to step forward and assist with testing or reagent development. Indiana developed a partnership with pharmaceutical company Eli Lilly to use its laboratories to analyze samples from healthcare settings and LTC facilities.13
• Deploy university medical schools and science research labs to facilitate testing or reagent development.

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• Dispatch mobile testing units to help with testing in rural areas. Utah is using mobile testing units to travel around the state and conduct tests in all LTC facilities, targeting rural areas.\(^{14}\)

Alongside creative partnerships, we believe the state should fund testing with mechanisms such as:

• Regular Testing for Staff:
  o Using existing insurance coverage for medically appropriate testing of staff, as often as medically appropriate, as required by Section 6001 of the Families First Coronavirus Response Act (FFCRA).\(^{[4]}\) State policy should define as medically appropriate the testing of all staff upon the occurrence of any known or suspected exposure and upon the occurrence of any single test-positive case in an LTC facility.
  o Requesting a Disaster Relief State Plan Amendment to use federal Medicaid funding to cover testing for staff that are uninsured as permitted under Section 6004(a)(3) of FFCRA (Section 1902(a)(10)(A)(ii)(XXIII) of the Social Security Act).
  o Require private insurers to cover and waive cost sharing for up to twice weekly COVID-19 tests for LTC facility staff, as New York state has done.\(^{15}\)
  o Making enhanced payments to Nursing Homes to cover the cost of tests.
  o Requiring RRHCPs to fund and provide testing.

• As Needed Testing for Residents:
  o Using existing Medicaid, Medicare, and private insurance for medically appropriate testing of residents, as often as medically appropriate, as required by the FFCRA. State policy should define as medically appropriate the testing all residents upon the occurrence of any known or suspected exposure and upon any single test-positive case in an LTC facility.
  o Require private insurance to cover COVID-19 testing for asymptomatic patients admitted to LTC facilities, as Massachusetts has required.\(^{16}\)

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\(^{[4]}\) [https://www.kff.org/coronavirus-covid-19/issue-brief/five-things-to-know-about-the-cost-of-covid-19-testing-and-treatment/](https://www.kff.org/coronavirus-covid-19/issue-brief/five-things-to-know-about-the-cost-of-covid-19-testing-and-treatment/) The Families First Coronavirus Response Act (FFCRA) (adopted in March 2020) requires “all forms of public and private insurance, including self-funded plans, must now cover FDA-approved COVID-19 tests and costs associated with diagnostic testing with no cost-sharing, as long as the test is deemed medically appropriate by an attending health care provider”. There is no limit on the number of COVID-19 tests may be covered for an individual, as long as each test is deemed medically appropriate and the individual either has signs or symptoms of COVID-19 or has had known or suspected recent exposure to the virus.


\(^{16}\) [https://www.commonwealthfund.org/publications/maps-and-interactive](https://www.commonwealthfund.org/publications/maps-and-interactive) state-action-related-covid-19-coverage-critical-services-private Maryland has interpreted “medically appropriate” to include residents and staff who need regular testing.
Different states have different approaches to funding tests, taking advantage of new federal opportunities for covering the cost. In New York, for example, facilities may submit claims for insurance coverage per the CARES Act. If insurance denies coverage, facilities must pay for the cost however the state may “facilitate FEMA or other federal reimbursement.” Sixteen states (AL, CA, CO, IA, IL, LA, ME, MN, MT, NH, NM, NV, RI, SC, UT, WA) have approved Medicaid Disaster Relief State Plan Amendments to cover all uninsured individuals in order to pay for their testing, while four other states provide testing for uninsured individuals under other authority (CT, MA, WV, TX).

Detection Recommendation #3
Mandate that hospitals test all individuals and determine their COVID-19 status before discharging them to an LTC facility.

State policy should require hospitals to know the COVID-19 status of an individual and be able to communicate this status to an LTC facility before the individual is discharged to that facility. Current state policy only requires that the test has been administered, not that a result (positive or negative) has been determined. This puts the facility, staff, other residents, and the individual being discharged at risk. Without information as to the current status of the returning resident or new admission, the LTC facility cannot be properly prepared.

Detection Recommendation #4
Require LTC facilities to keep logs, track contacts, to facilitate contact tracing.

A facility best practice being shared nationally is for facilities to conduct their own, internal, contact tracing work. Facility level contact tracing involves proactively tracking all contacts between staff and residents and outsiders at the individual level, in a log retained on site. In the event a COVID-19 case is found, this preemptive contact tracing will facilitate swift action to isolate those who might have been exposed. Pennsylvania should require LTC facility contact tracing as an ongoing detection and prevention activity. Once a case is found, Pennsylvania should require facility cooperation with local county health departments, or the state health department contact tracing activities. Local and state contact tracing protocols should prioritize the notification of any other facility at which a staff member works, in the event the staff was found to be COVID+ or to have been exposed to COVID.

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Whatever contact tracing the RRHCPs facilitate during their four months, must be institutionalized so that the activities can continue after December 1, 2020.

C. Prevention

Pennsylvania must do more to stop the spread of COVID-19 into and within LTC facilities. The four main ways the virus penetrates a long term care setting are: 1) staff, vendors, or contractors who come in and out of the building, 2) new admissions, 3) outside medical appointments, and 4) visitors.19 Once COVID-19 is in a facility, there are several ways that it can spread: 1) surfaces/objects, 2) airborne respiratory droplets that linger or can be transmitted through HVAC systems, 3) patient-to-patient contact, or 3) patient-to-staff-to-patient contact.20

In order to prevent COVID-19 from spreading, Pennsylvania must adopt more stringent measures than those currently in place. We recommend the following precautions:

Prevention Recommendation #1
Ensure access to sufficient PPE so that all facility residents and staff may comply with evidence-based best practices for use, cleaning, and replacement of PPE.

PPE must be available for all staff and residents to prevent the spread of COVID-19. The state must assist with PPE acquisition. If necessary, to make PPE available to all LTC facilities at levels recommended by evidence-based best practices, the state must take control of the supply and distribution of PPE. The state must also issue regulations articulating requirements for use, cleaning, and replacement consistent with those evidence-based best practices as well as for ensuring LTC facilities maintain the appropriate levels of PPE on hand. Additionally, the state must provide effective decontamination procedures and assure PPE is in stock.

Pennsylvania has developed a portal through which suppliers can share availability of PPE.21 This portal, however, does not ensure PPE attainment. The states of Minnesota, Mississippi, South Carolina, Washington, and Idaho help NFs obtain PPE.22 Additionally, in AL, IN, MA, MS, MT, NM, ND, OH and CT, the states are paying for the use of the Battelle CCDS Critical Care Decontamination System™ to decontaminate existing supplies of N95s and other PPE.23

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20 Ibid.
21 [https://spportal.dot.pa.gov/ppeinventory/Pages/default.aspx](https://spportal.dot.pa.gov/ppeinventory/Pages/default.aspx)
22 CMS Toolkit.
23 CMS Toolkit. This system can clean up to 80,000 units per day.
While the RRHCPs are responsible for assisting with PPE attainment in their regions, they are not required to guarantee attainment and their existence is time-limited, for the next four months.

**Prevention Recommendation #2**

Require and provide training in proper use of PPE for staff and residents in LTC facilities.

Staff and residents must be trained in the proper use of PPE. Instruction in and requirements around donning and doffing of PPE is essential. Experience in the field is revealing that not all staff and residents are familiar with the proper way to don and doff a mask nor with how to ensure the mask has an airtight fit. Pennsylvania needs to act to make sure that PPE is serving its purpose, must require staff to demonstrate competency after being trained, and must monitor the ongoing effective use of PPE.

While the RRHCPs have plans to assist in training around proper use of PPE, they must aide in developing and implementing strategies for training that will continue when the RRHCPs end on December 1, 2020.

Examples from other states:
- In Alabama, specially trained National Guard teams are training in donning and doffing.\(^{24}\)
- Mississippi has developed a tool for tracking observed PPE and hygiene practices before and after contact with residents.\(^ {25}\)

**Prevention Recommendation #3**

Mandate new, COVID-specific, effective cleaning and disinfecting processes and procedures.

LTC facilities must be correctly and frequently cleaned to prevent the spread of COVID-19. COVID-19 has created new challenges and requires new cleaning and disinfecting standards, such as the CDC has developed.\(^ {26}\) LTC facility staff must be trained in cleaning and disinfecting procedures. LTC facilities must be required to adopt COVID-specific changes such as HEPA air filtration or UV cleaning processes. Pennsylvania must include COVID-specific cleaning and disinfecting requirements in its LTC facility regulations. COVID-specific procedures being used in other states include:
- AZ is using UV machines to disinfect iPads, nurse cart keys, and more.\(^ {27}\)

\(^{24}\) CMS Toolkit.


\(^{27}\) CMS Toolkit.
• Georgia is one of many states using the National Guard for cleaning.\(^2^8\)

**Prevention Recommendation #4**

Monitor and ensure staff personal hygiene practices.

In the years leading up to COVID-19, infection control violations were the number one violation in nursing facilities around the country. Non-compliance with existing requirements was vast and dangerous. Even since COVID-19 began to spread in the United States, federal nursing home surveyors have found personal hygiene failures by nursing facility staff. Imposing new requirements will not prevent the spread if they are not followed and practices are not monitored. Pennsylvania has a Hand Hygiene Audit Tool.\(^2^9\) Its use must be required, and results must be retained for monitoring and oversight review. Audit tool results must be checked in surveys and cited at a level that compels compliance.

**Prevention Recommendation #5**

Authorize, encourage the use of, and financially support a strategy of cohorting residents.

Cohorting allows for clustering COVID-19 positive individuals in designated wings or separate facilities that are tailored to meet COVID-19 infection control and treatment needs.\(^3^0\) Cohorting is widely recommended.\(^3^1\) It is permitted at this time under a relaxation of federal nursing home regulations but it is not required. There are no uniform standards applied in the selection of COVID-only facilities or how they must operate, what minimum requirements they must follow, how residents’ rights are to be protected, and more.

Pennsylvania must outline uniform standards governing cohorting in LTC facilities. In so doing, the state should require 1) quality standards for facilities that are cohorting\(^3^2\), 2) private rooms, when possible, 2) 24 hour RN presence, 3) Staffing levels of at least 4.1 hours per resident per day, 4) Presence of a full-time infection preventionist, 5) minimum PPE and testing requirements, 6) specific training for staff, and 7) separate staffing for cohorted units.\(^3^3\)

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\(^2^8\) CMS Toolkit.

\(^2^9\) [https://www.health.pa.gov/topics/programs/HAIP-AS/Pages/Healthcare.aspx](https://www.health.pa.gov/topics/programs/HAIP-AS/Pages/Healthcare.aspx)

\(^3^0\) States allowing COVID only Facilities or units: Connecticut, New York, Delaware, Georgia, Idaho, Massachusetts, Minnesota, Ohio, New Mexico, Nevada.


\(^3^2\) CMS Toolkit. San Mateo County designated COVID only SNFs as centers of excellence based on their record of infection control performance.

\(^3^3\) States with designated staff for COVID-only rooms, wings, floors, or facilities: Delaware, Georgia, Massachusetts.
The state should also fund the creation of and increase the funding for delivery of services in cohorted wings or LTC facilities. Connecticut, for example, provides start-up funds for new, developing COVID-only facilities. It also pays $600/bed/day rate for COVID-only facilities (which is double the normal rate) and allows the temporary use of buildings that have not previously been approved as nursing facilities to serve as COVID-only nursing facilities.

_Prevention Recommendation #6_
Articulate requirements for facilities to cohort staff.

Just as standards need to be set of the cohorting of residents (which we recommend above), requirements should be set for cohorting LTC facility staff to limit the risks of cross-contamination by staff. One recent study found that 44% of COVID-19 deaths in nursing facilities could have been prevented if staff had been prevented from moving from COVID positive to COVID-negative portions of LTC facilities. Under cohorting policies, standards would need to be followed to ensure that designated staff would be committed to COVID-19 positive patients and this cohort would not interact with COVID-19 negative patients. New Mexico has designated staff for COVID-19 only wings/facilities.

_Prevention Recommendation #7_
Ensure that all transfers of COVID+ residents are done safely to ensure proper care for these residents and to prevent an outbreak in the receiving facility.

Pennsylvania must articulate requirements outlining how residents are to be transferred across settings, detailing distinct processes for COVID+, COVID-, and COVID? individuals. The state must detail requirements both for the sending and the receiving facilities.

Other states have recognized the importance of safely transferring individual residents along with information about their COVID status and their care needs. Georgia created a transfer form for information sharing through the healthcare system when transferring out of and back into a nursing facility. Illinois, Virginia, West Virginia, and Kentucky developed guidance to be followed for all transfers. The state of Washington, with support of the hospital and nursing home associations, developed a standardized state-wide process for the state to assist in coordinating discharges from hospitals to nursing homes so as not to overwhelm any one facility.

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35 CMS Toolkit.
36 CMS Toolkit.
37 CMS Toolkit.
38 CMS Toolkit.
Prevention Recommendation #8
Require each LTC facility to employ a full-time, trained infection preventionist.

Infection control violations are and have been widespread in LTC facilities, long predating the outbreak of COVID-19. These years of infection control violations have occurred in nursing facilities notwithstanding a federal nursing home regulation that requires facilities to develop infection control programs and to designate a person to serve as infection preventionist.\(^{39}\) Federal regulations, however, only require that the individual designated to serve as infection preventionist be someone who works at least part-time at the facility.

In light of the pre-existing non-compliance with infection control requirements and the gravity of a COVID-19 outbreak, we do not believe the part-time infection preventionist is requirement sufficient. Pennsylvania must require and fund a full-time infection preventionist for each facility.\(^{40}\) LTC facilities around the country that have successfully staved off COVID-19 from entering often boast of having a full-time infection preventionist.\(^{41}\) One Baltimore nursing facility with a full-time infection preventionist can boast of both a squeaky clean record of no infection control violations over the past four years and not a single COVID-19 case amongst staff or residents.\(^{42}\)

The CDC has recently published a new, free Nursing Home Infection Preventionist Training course.\(^{43}\) Pennsylvania should require LTC facility administrators along with the nursing facility’s full-time infection preventionist to complete this training. Assisted Living Facility and Personal Care Home regulations should require completion of infection prevention training.

D. Response/Mitigation

Response/Mitigation Recommendation #1
Conduct weekly LTC facility-specific information sharing sessions with LTC facility stakeholders and the public.

The Departments of Health, Human Services, and Aging should jointly conduct weekly huddles specifically targeting LTC facilities with the express purpose of disseminating information to, providing and explaining policy updates, sharing best practices and lessons learned, and answering questions from LTC facility stakeholders.

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\(^{40}\) Recommended by: H.R. 6698, LTCCC, The Consumer Voice


\(^{42}\) Ibid.

\(^{43}\) [https://www.cdc.gov/longtermcare/training.html](https://www.cdc.gov/longtermcare/training.html)
administrators, staff, residents, resident representatives, families, and advocates. Connecticut is holding daily calls to disseminate info and doing virtual huddles with infectious disease specialists for training as well. Massachusetts is doing weekly calls with all facilities that are open to the public. The John A. Hartford Foundation and IHI sponsor national nursing home huddles every weekday at noon for twenty minutes and they are very well-received and helpful to providers.\(^{44}\)

**Response/Mitigation Recommendation #2**

**Require all LTC facilities to collaborate with and accept intervention from the Regional Resource Health Collaboratives (RRHCPs) and measure the RRHCPs’ success and efficacy.**

We welcome the start of the new Regional Resource Health Collaboration Program (RRHCP) that is available to support LTC facilities. We believe these Collaboratives will offer a valuable resource to facilities. We urge the Departments of Health and Human Services to require all LTC facilities to participate with and accept the help of the RRHCPs. The departments should also require the RRHCPs to develop relationships and collaborate with the state and local LTC Ombudsman programs. We call on the Departments to outline parameters for monitoring the work of the RRHCPs and for collecting, reporting, and disseminating information from each of the RRHCPs on both their work and potentially promising practices as they are identified. We also urge the state to openly and regularly share the activities and successes of the RRHCPs.

**Response/Mitigation Recommendation #3**

**Make direct payments to LTC facilities exclusively for increased payments to staff, infection control, PPE, testing, etc.**

Pennsylvania must direct monies to LTC facilities, especially those facilities that have a high Medicaid population/census which are the most challenged and generally the least resourced, specifically to cover making increased payments to staff, to address infection control needs, and to obtain PPE or testing. Maine, Massachusetts, Indiana, and Connecticut have all increased rates.\(^{45}\)

**Response/Mitigation Recommendation #4**

**Have hospitals and health systems adopt LTC facilities and commit to providing rapid response to their adopted facilities.**


\(^{45}\) CMS Toolkit. Massachusetts increased Masshealth rates for nursing facilities by 10%, Indiana is providing 50% increased reimbursement to COVID NFs, Connecticut is paying a 15% Medicaid rate increase for non-COVID beds for March through June (COVID beds are reimbursed by Medicare because 3 day stay is waived) for increased wages, supplies, etc. as well as a $600/day payment (twice the normal rate) to COVID-only facilities and $400 to other facilities for COVID patients.
The state must request participation in and provide resources to support collaborations between hospitals and LTC facilities. Hospital nurses with infection control expertise, and often more infection control experience than LTC facility-based nurses, could go on-site to do readiness assessments, to conduct infection control training, and to develop action plans to address gaps in resources and care. They also could conduct follow up to assist the LTC facilities with those action plans.

The RRHCPs will be providing rapid response teams to facilities in their region during their four months of operation. They should be required to identify best practices and to develop and implement a plan for hospital/health system and LTC facility collaborations and rapid response after they disband.

This is being done in places like Seattle⁴⁶ and Toronto⁴⁷, and being recommended by academics and medical experts.⁴⁸ In one example, in Contra Costa County, California, county officials asked John Muir Health, a community hospital system, to provide emergency staffing and infection control training for a nursing home with a large outbreak. After this first successful effort, all hospitals and nursing homes in the county were matched.⁴⁹ This was then copied in Alameda County.⁵⁰

**Response/Mitigation Recommendation #5**  
Require LTC facilities to develop and submit for DOH approval their own COVID-19 Mitigation Plans.

The state should mandate that all facilities develop and submit a written COVID-19 and other pandemic mitigation and response plan. Similar to an Emergency Preparedness Plan and drafted to work in concert with Emergency Preparedness Plans, LTC facilities can use these COVID-19 and other Pandemic Response Plans to outline everything they specifically will do related to:

- Testing and cohorting
- Infection prevention and control
- Personal protective equipment (PPE)
- Staffing shortages
- Designation of space
- Communication

This is being done in California and Nebraska already.⁵¹ The state should provide technical assistance or models that LTC Facilities could use. Each LTC facility should

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⁴⁶ https://www.jamda.com/action/showPdf?pii=S1525-8610%2820%2930447-3
⁴⁹ CMS Toolkit.
⁵⁰ CMS Toolkit.
⁵¹ CMS Toolkit.
receive technical assistance from the RRHCPs in developing these plans and should have them in place by December 1, 2020.

E. Communication and Transparency

Communication and Transparency Recommendation #1
Revise LTC facility regulations and do so through a transparent, public process that includes stakeholder input into revisions.

Pennsylvania needs to overhaul its regulations, establishing and the enforcing conditions that deliver high quality of care for all residents, regardless of payer source. Racial and payer disparities must be eliminated. Standards must be improved. The state must use a public, open-access, iterative discussion process to determine the changes needed and the standards to set.

Communication and Transparency Recommendation #2
Share more information with stakeholders and the public by 1) ensuring the integrity of the data being collected, 2) collecting more information than is already being collected (such as total number of tests administered, total number of all deaths, total numbers of staff and residents by shift) and 3) sharing the additional data once it is collected.

Pennsylvania is following new CMS rules that require states to report facility level data with the CDC and CMS, and this data gets posted weekly. This information should be posted daily instead of weekly and should include more than is presently being made public. PA is now publishing the number of cases and deaths among residents and staff, by facility, once a week. We are pleased to see this, however, we have genuine concerns about the completeness of the data being reported (with many facilities reporting “no data”). Additionally, we would like to see the following information made public weekly:

   i. Available PPE and projected need, by facility.  
   ii. Staffing need and actual staffing levels, by facility.  
   iii. Number of tests conducted, by facility. 
   iv. Total number of non-COVID-19 fatalities, by facility

Breakdown demographic information (including age, gender, race, and payer source) of resident and staff cases and deaths, by facility (Racial demographics need analysis to study impact of COVID 19 on people of color (staff and residents) to learn what we can do to mitigate impact.)

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52 Some of the additional information that could be shared would be required by H.R. 6698.  
53 According to the CMS Toolkit, NJ and NM are reporting this.  
54 According to the CMS Toolkit, CA is reporting this.  
55 According to the CMS Toolkit, FL is reporting this.
**Communication and Transparency Recommendation #3**  
**Establish a Statewide Long-Term Services and Supports (LTSS) Emergency Response Task Force.**

The Governor’s Policy Office should establish a statewide, inter-agency Task Force with DHS, DOH, PDA, and PEMA that is inclusive of ALL key stakeholders, including at least one LTC facility resident representative or resident council president. This task force should be used to bring forward pressing issues for discussion, review best practices and recommend/implement solutions. It should cover the entire continuum of LTSS. The task force must be a racially diverse body with a core focus to address racial disparity in LTC facilities and, specifically, racially disparate outcomes from COVID-19 and other chronic health conditions. Its scope should include both emergency and pandemic preparedness and response, addressing COVID-19 and other similar threats.

**Communication and Transparency Recommendation #4**  
**Streamline the information, guidance, tools, and other COVID-related long-term care facility materials on the Departments’ websites into a single electronic manual.**

It is hard to navigate all the different rules, orders, and guidance emanating from the Administration. It can be confusing trying to piece all the different press releases and publications together. Putting them all together in one single electronic location with title headers and a dynamic table of contents would improve the ability of facilities and the public to navigate the governing information.

CMS formats many of its guidance documents in this way so that all of its program specific rules and policies are presented in a single electronic manual with a hyperlinked table of contents and covers all rules a provider would need to know.56

**F. Staffing/Workforce**

There can be no doubt that the state’s COVID-19 policy approach can only be successful if the LTC facilities are staffed appropriately to mitigate risk while following required processes and procedures. Staffing and workforce issues in Pennsylvania’s LTC facilities long predate the onset of COVID-19. Staffing regulations across all LTC facility types do not guarantee enough staff hours to meet residents’ pre-COVID-19 care needs. Staff wages are so low that we commonly find staff who may work at multiple LTC facilities or other jobs to earn a livable wage. These factors have contributed to the COVID-19 crisis in LTC facilities. We must address long-standing staffing/workforce issues as well as the COVID-19 specific staffing/workforce issues if we have any hope of preventing another LTC facility crisis.

56 CMS Toolkit. Texas is one of the states that has incorporated all of its rules and policies into a single electronic manual with a hyperlinked table of contents that covers all rules put into place for the COVID response.
**Staffing/Workforce Recommendation #1**

Establish new, enhanced staffing requirements specific to COVID-19 and any future pandemic.

A study out of California published in July 2020 showed that nursing homes with total “RN staffing levels under the recommended minimum standard (0.75 hours per resident day) had a two times greater probability of having COVID-19 resident infections. Nursing homes with lower Medicare five-star ratings on total nurse and RN staffing levels (adjusted for acuity), higher total health deficiencies, and more beds had a higher probability of having COVID-19 infections. Nursing homes with low RN and total staffing levels appear to leave residents vulnerable to COVID-19 infections.” We must enhance staffing standards to address COVID-19 and future pandemics. A similar study out of Connecticut shows that low staffing levels leads to worse outcomes.

**Staffing/Workforce Recommendation #2**

Help LTC facilities recruit and hire more staff in times of crisis, like COVID-19.

Pennsylvania must do more to increase the availability of staff to LTC facilities. There are multiple actions the state can take to help with staffing challenges. Other states have undertaken efforts to authorize temporary staff with similar professional licensures, expedite training, permit provider licensure flexibility, allow emergency credentialing, encourage the use of medical professional volunteers, use state dollars to incentivize staff to remain in or return to the workforce, and more. National provider associations are likewise asking state to proactively require, train, and deploy additional workers for LTC facilities.

Pennsylvania is already allowing individuals with only 8 hours of training to serve in nursing facilities, in an effort to get more staff working. We feel strongly that temporary changes to training or credentialing requirements should be lifted when the crisis subsides and staff hired during that time, without meeting the usual requirements, should be granted time to meet the training and competency requirements.

Pennsylvania must do more to identify and make lasting changes to increase the availability of LTSS staff for all settings. It must also allow essential caregivers back into LTC facilities where they have long cared for and supplemented the facilities’ services for their residents.

Examples of steps other states are taking:

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• Louisiana is directly assisting in connecting potential staff to facilities who need them.  

59 Minnesota and Massachusetts are also assisting in the hiring process.

• North Carolina is assisting healthcare professionals who are willing to pick up extra work/shifts helping with the crisis, using a website form to assist with matching.

61 Massachusetts is providing new hires with a $1,000 signing bonus paid by the state.  

62 New Hampshire is also using state dollars to pay staff to remain or return to the workforce.

• Illinois was one of 8 states working with the AMA to help connect volunteer health professionals with volunteer opportunities in LTC facilities.  

63 Montana is also working to connect health care professionals to volunteer positions.

Rhode Island offers recruitment and management of Rhode Island's health care volunteers under one state-wide system.

65 • West Virginia has a website through which medical and non-medical volunteers can register to volunteer during this emergency.

Santa Clara County published a survey to determine available skills within the community and to help find community volunteers with professional and non-professional credentials to be able to assist with anything from nursing to social work and janitorial services.

67 • New Jersey authorized EMTs and HHAs to temporarily serve as CNAs in NFs.

Los Angeles authorized EMTs to serve as nurses’ aides in SNFs.

Wisconsin modified its Nurse Aide Training to address the need for additional nursing assistants.

69 • Delaware removed restrictions on out-of-state health care workers to assist in COVID-19 response.

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59 CMS Toolkit. Through the Louisiana Health Work Connect program, interested workers submit their info to the state using a form. The Department provides a list of candidates to facilities tailored to their staffing needs. A participating facility then contacts a healthcare worker to begin the hiring process.

https://healthworkconnect.la.gov

60 CMS Toolkit.

61 CMS Toolkit.


63 CMS Toolkit. The AMA Guide includes information for physicians and health care professionals to support communities severely impacted by COVID-19. It tells how and where to volunteer—and things to consider before registering. For state agencies and institutions, the guide includes information on third-party organizations that can identify and match volunteers accordingly, as well as resources for credentialing in an emergency.


64 CMS Toolkit.

65 CMS Toolkit. Rhode Island Responds website can be found here: http://www.riresponds.org

66 CMS Toolkit. The West Virginia tool is available here: https://www.wvredi.org/agreement.php

67 https://www.surveymonkey.com/r/BMZ9GCM

68 CMS Toolkit.

69 CMS Toolkit.

70 CMS Toolkit.

71 CMS Toolkit.
• Florida also extended health care practitioner licensure to avoid lapse and
allowed reactivation of licensure for those whose license lapsed in the last two
years.  

**Staffing/Workforce Recommendation #3**

During this and any future pandemic, require facilities to pay and subsidize, where
appropriate, hazard pay for LTC facility staff, both for the risk they are putting
themselves under and the risks we are asking them to avoid when not at work.

Pennsylvania just announced a short-term Hazard Pay grant program funded with
CARES Act funding. This will provide a much-needed increase of up to $3/hour for
those making up to $20/hour or a total of $1200 for those making more than that
over a ten-week period. We applaud Governor Wolf for taking this step to help front
line workers. The grant application process occurred at the end of July. We urge
Pennsylvania to increase the length of time and eligibility for this program. We urge
the state to mandate hazard pay for LTC facility workers, with priority for lower-paid
workers. Rhode Island is successfully providing this type of payment both as an
acknowledgement of the risk of working with COVID+ residents as well as an
incentive to remain vigilant when staff leave the LTC facility at the end of their
shifts. The state must explore additional ways to subsidize and pay for hazard pay
beyond the period and amount recently authorized.

**Staffing/Workforce Recommendation #4**

Require facilities to post actual staffing levels (not only a self-identified staffing
shortage) daily.

CMS is requiring LTC facilities to report any self-identified staffing shortage. This
subjective determination does not allow families or the public to understand what
actual staff is present in the facility. Actual staffing data information should be
posted on the outside door of the LTC facility along with information about the
number of residents and the staffing complement that should be present in the
facility based on the residents and their needs.

**Staffing/Workforce Recommendation #5**

Guarantee all LTC facilities’ staff at least two weeks of sick pay and protection
against being penalized for using sick time.

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72 CMS Toolkit.
73 Through Department of Community and Economic Development
75 Recommended by: LTCCC, 48 Advocacy Orgs
Pennsylvania’s legislature should enact legislation to require that all LTC facility staff are provided with two weeks paid sick leave. Additionally, LTC facility staff who become sick from COVID-19 while on the job should continue to be paid their salary, and not be required to take sick leave.

**Staffing/Workforce Recommendation #6**
Mandate COVID-19 specific training for LTC facility staff.

Pennsylvania must require and provide COVID-specific training in topics such as cleaning and disinfection, proper use and fitting of PPE, recognizing symptoms, treating COVID-19, residents’ rights during COVID-19, continuing to provide person-centered care even in a pandemic, and supporting residents through the social isolation caused by COVID-19 – physically, emotionally, and technologically where appropriate to help with connecting virtually with family.

**Staffing/Workforce Recommendation #7**
During an instance of widespread infection in a facility, provide emergency funds to pay for housing of LTC facility staff on-site or in a safe, secure location.

Pennsylvania should pilot providing funding to pay for housing of staff of LTC facilities. A Connecticut Provider is successfully housing all staff on site to prevent COVID from coming into his facility. A Georgia provider is doing the same. An Ohio provider is too. And a similar approach in France also saw success. A fund to support creative housing approaches to close the bubble around outbreak facilities should be created. Many hospital medical staff have been housed through efforts to contain exposure. LTC facility staff are similarly at risk of exposure and creative efforts to house them should be funded and tested.

### G. Other Resident-Specific Recommendations

**Other Resident Specific Recommendation #1**
Facilitate expedited Nursing Home Transition (NHT) and other moves out of LTC facilities, even if just temporary, and guarantee residents the right to return after the crisis.

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76 Recommended by HR 6698, The Consumer Voice. In PA, PA Senate Bill S80 and House companion bill 1739 does address a statewide paid leave program. These bills are referred to as the Family Care Act and AARP PA is a member of the Families First Coalition that is advocating for its passage in PA.

77 Recommended by HR 6698, The Consumer Voice

78 [https://www.wbur.org/hereandnow/2020/05/18/nursing-home-coronavirus-rvs](https://www.wbur.org/hereandnow/2020/05/18/nursing-home-coronavirus-rvs)


The state must recognize that some residents will be safer or more comfortable leaving their LTC facility during a COVID-19 outbreak and receiving long-term services and supports in their own homes, possibly with family on a temporary or permanent basis. This must be permitted, publicized, expedited, and facilitated. Individuals who choose to leave temporarily must be guaranteed the right to return to their LTC facility at the end of the outbreak or pandemic.\(^{82}\) Make Ombudsman and other NHT support available to expedite and assist in these transitions. Michigan has adopted this approach and guarantees the right to return.\(^{83}\)

Some specific mechanisms the state should explore:

- DHS should consider amending its Appendix K for the CHC waiver to include b.iv-“Temporarily expand setting(s) where services may be provided (e.g. hotels, shelters, schools, churches)” to allow Community HealthChoices Managed Care Organizations (CHC MCOs) to pay for temporary housing and services in hotels and college dormitories to move willing residents out quickly while the NHT process moves forward.

- DHS, DoH and PEMA should work together to identify and support an entity that is willing and qualified to serve as applicant for FEMA Category B funds for Non-Congregate Sheltering. That applicant would then contract with interested NHT agencies who would arrange for temporary housing (hotels and dormitories) and services in that housing until the resident either returns to his/her nursing facility or is transitioned into permanent housing with supports through CHC waiver. Possible applicant entities include Regional Health Care Coalitions and RRHCP grantees. The required 25% match for FEMA funds should be provided by the state as the potential applicants would serve primarily as passthroughs to contracted NHT programs and are not likely to have the funds needed for the match.

- DHS should research other possible funding sources for temporary accessible housing and services for residents wishing to quickly relocate from their nursing facility.

- DHS should work closely with its NHT subcommittee to develop protocols and billing mechanisms for temporary relocation of nursing facility residents and revisions to current Medicaid waiver enrollment requirements to enable expedited waiver enrollment for NH residents seeking to transition from their nursing facility.

Other Resident-Specific Recommendation #2
Resume on-site access for residents’ attorneys and fiduciaries.

Pennsylvania must resume on-site access to residents for their attorneys/counsel and fiduciaries such as agents and guardians, who are legally required to be ensuring

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\(^{82}\) Recommended by: HR 6698, 48 Advocacy Orgs, LTCCC  
\(^{83}\) Michigan executive order 2020-50)
well-being of residents as well as helping them plan and execute urgently needed documents for their health, end of life and financial care decision-making. These individuals are also critical in addressing neglect, abuse and exploitation. Without question, these individuals should follow the processes for safe visitation/entry into an LTC Facility that we recommend in Residents’ Rights Recommendation #5 above.

Other Resident-Specific Recommendation #3
Resume safe and sustainable communal activities.

Residents in LTC facilities have a higher risk from COVID-19 in part because they live in close quarters making recommended physical distancing difficult. As a result, many facilities have taken measures not only restricting visitors but also restricting group activities which can negatively affect the physical and mental health of residents. These restrictions create problems related to lack of social connections with fellow residents, exercise, and recreational activities. Limited opportunities for physical activity may result in weakness and functional decline while breaks in routine and restrictions may cause cognitive decline in people with dementia.

Sustainable strategies need to be implemented to lift restrictive policies with appropriate safety measures in place to meet these needs including ensuring residents can leave their rooms such as for exercise and fresh air. Communal activities such as recreation and dining with safety protocols, like very small groups one at a time or staggered meal times, are essential to help improve health and wellbeing.

H. Monitoring and Oversight

Monitoring and Oversight Recommendation #1
Resume in-person, on-site monitoring and annual surveys for all LTC facilities with safety precautions in place.

Pennsylvania must immediately resume its survey activities for all LTC facilities, including annual surveys which had been temporarily suspended. The state must take enforcement action against facilities which are not in compliance with licensing requirements.\textsuperscript{84} Infection Control was the top violation for nursing facilities before COVID-19 and remains a significant area of non-compliance. The GAO recently released a report on widespread and persistent infection control deficiencies prior to COVID-19.\textsuperscript{85} If it were the case that all facilities have perpetually compliant, strong performance on all regulatory requirements and quality metrics, it might be acceptable to continue the current absence of oversight. However, this is not a

\textsuperscript{84} Recommended by: LTCC, The Consumer Voice, CMA,
\textsuperscript{85} https://www.gao.gov/assets/710/707069.pdf
successfully self-policing industry and monitoring and oversight are and have been essential to ensuring the health and safety of residents.

Not only must monitoring visits resume but so must enforcement action.

It is important to distinguish between poor performers with pre-existing problems and good performers without pre-existing infection control problems. It may not be the facilities’ fault that COVID-19 comes in. But, not all facilities are taking the appropriate action once it comes in. For example, are the facilities actually complying with current infection control requirements and COVID-19 specific guidance? Or are they non-compliant? A CMS survey in April shows 36% of facilities surveyed had infection control violations around proper handwashing during the COVID-19 crisis, and these were preexisting infection control requirements.  

Multiple states, including FL, CT, and ND, have resumed conducting in person surveys and licensing visits. By contrast, Georgia is conducting virtual visits. New Mexico is also doing virtual video audits to verify cleaning protocols and proper use of PPE.

**Monitoring and Oversight Recommendation #2**
Resume in-person, onsite monitoring and other visits by Long Term Care Ombudsman and Older Adult Protective Services (OAPS)/Adult Protective Services (APS), with evidence-based safety precautions in place.

OAPS/APS and the LTC Ombudsman Program (LTCOP) play an essential role in keeping residents safe. It is imperative that local ombudsmen resume on-site visits to investigate complaints of any nature and not just where there is concern for serious bodily injury, sexual abuse, or serious physical injury. The Departments of Health and Aging must publish and enforce requirements that facilities let the LTCOP and OAPS/APS into facilities to do their jobs.

**Monitoring and Oversight Recommendation #3**
Employ daily virtual monitoring and oversight in LTC facilities with COVID+ patients.

Pennsylvania must employ daily virtual monitoring and oversight in LTC facilities with COVID+ residents. It is essential to observe facilities where COVID is present. Connecticut is having daily calls with all COVID+ facilities and conducting Facetime visits.

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87 CMS Toolkit.
88 CMS Toolkit.
89 CMS Toolkit.
90 LTCCC Recommendation for daily monitoring of facilities with COVID+
calls to verify the presence of and the number of staff, as well as the proper use of PPE. Pennsylvania should implement similar processes. Likewise, LTC facility management would use a video call with DOH and walk through their facility with their video on, allowing state staff to view over video the facility and staff and allowing state staff to, through the video call, visually verify compliance with cleaning and disinfecting procedures. For now, the RRHCPs could undertake this daily contact, providing technical assistance and training. When the RRHCP’s work is done on December, DOH and DHS survey staff must be prepared to maintain this daily contact for video monitoring.

**Monitoring and Oversight Recommendation #4**

Reject legal immunity for LTC facilities in Pennsylvania.

Governor Wolf issued an Executive Order providing immunity for health care workers. The LTC facility industry is lobbying for immunity for LTC facilities, on the state and federal levels. They seek to obtain a blanket protection for all facilities for all harms perpetrated against residents during the COVID-19 crisis and for several years to follow.

We oppose immunity for LTC facilities. Pennsylvania must reject immunity for facilities in order to ensure safety for residents and accountability for providers.

**Monitoring and Oversight Recommendation #5**

Calculate what staffing and resources DOH needs to implement these recommendations, and other necessary COVID-related steps, to improve conditions for LTC facility residents and then allocate appropriate funding for the undertaking.

The Department of Health is understaffed and under-resourced. Increasing DOH funding must be a priority for the legislature and this administration. DOH cannot possibly take all necessary steps to keep Pennsylvanians safe without the staff and resources to do so.

I. Volunteerism

**Volunteerism Recommendation #1**

Encourage private individuals to volunteer to support residents and their families and facilitate private individuals’ connection to volunteer opportunities.

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91 CMS Toolkit.
Pennsylvania has a Civil Volunteer registry. Through this registry, Pennsylvanians can volunteer to be contact tracers. This registry could be leveraged and employed to provide more help with the COVID-19 crisis such as identifying medical and non-medical volunteers. Volunteers could also be used to engage remotely with LTC residents who do not have family/friend support or to help train residents to be able to self-manage technology.

Other states are doing this. For example: MA has a website through which people can donate PPE, volunteer, help with contact tracing, etc. Rhode Island offers recruitment and management of Rhode Island’s health care volunteers under one state-wide system through which volunteers can sign up to be on one of three teams: 1) The Rhode Island Disaster Medical Assistance Team’s Medical Reserve Corps, 2) The Statewide Emergency Registry of Volunteers (SERV-RI), and 3) Disaster Behavioral Health Response Team (DBHRT). West Virginia has a web-based system through which the state can identify, credential, and deploy West Virginians willing to serve in an emergency, as well as non-emergent situations. It is open to health and medical professionals, as well as others who live or work in West Virginia and are willing to assist during a health-related emergency or event. New York City has a volunteer network of over 2500 mental health professionals, spiritual care workers, and more providing free support to essential workers, their families, and any uninsured New Yorker.

93 https://www.mass.gov/info-details/covid-19-updates-and-information#help-out
94 http://www.riresponds.org
95 https://www.wvredi.org/
96 https://nyccovidcare.org/